Number: 5-1
Participation
Effective/Revised Date: October 1, 1997

Participation

Purpose
To increase WIC participation in Montana.

Authority
State Policy

Policy
At least 75% of the potentially income eligible persons in Montana be enrolled in the WIC Program.

Guidelines

I. Income Eligibility

The federal Poverty Income Guidelines will be used to determine financial eligibility statewide. See State Plan section on definitions for use of Adjunctive Eligibility for income eligibility. **Note:** The Poverty Income Guidelines will be implemented annually, effective simultaneously with the Montana Medicaid income guidelines.

II. Categorical Eligibility

A. The following people are categorically eligible for WIC services:
   1. Women - Pregnant - Breastfeeding - Postpartum
   2. Infants to one year of age, and
   3. Children to age five

III. Nutritional Eligibility

The local agency Competent Professional Authority will determine the nutritional and/or medical reason(s) for receipt of WIC services and certify eligibility for one certification period.

IV. Priorities Served

WIC Program Priorities I through VI will be served. Policy 5-10 describes the priorities.

V. Participation Increases

Local WIC programs will take steps to increase their participation rates in a manner consistent with program regulations to maintain a minimum 75% level at all times.

Income Guidelines

Purpose
To ensure Local Agencies apply current income standards to all WIC applicants

Authority
CFR Part 246.7

Policy
Current WIC income guidelines will be used to determine financial eligibility.

The terms "economic unit" and "family" can be used interchangeably. We perceive a family to be a household or an economic unit composed of a person or group of persons who usually (although not necessarily) live together and whose production of income and consumption of goods or services are shared.

Guidelines

I. Background

WIC Income Guidelines are implemented concurrently with Medicaid Income Guidelines. This facilitates adjunctive eligibility determinations and referrals

II. WIC Income Guidelines

A. Use the table below to determine WIC income eligibility

If family size (including unborn) is	The yearly gross standard is
1	$18,130
2	$24,420
3	$30,710
4	$37,000
5	$43,290
6	$49,580
7	$55,870
8	$62,160
Additional Family Members	**add $6,290**

III. Use the table below to refer families to Medicaid.

Comment: These figures are examples only. Medicaid income determinations are calculated differently than those for the WIC Program.

If family size is	The MEDICAID monthly gross standard is
1	$1,086
2	$1,463
3	$1,840
4	$2,217
5	$2,594
6	$2,970
7	$3,347
8	$3,724

IV. References

Table of Standards (FMA 004) effective April 1, 2006, H & C Services

Policy Number: 5-3
Income Eligibility of Pregnant Women
Effective/Revised Date: October 1, 1997

Income Eligibility of Pregnant Women

Purpose
To increase the household size of pregnant women applying for WIC benefits if they are determined over income at certification

Authority
PL 103-448; USDA Policy MPSF-1: WC-95-34-P; ARM 46.10.321; ARM 46.12.3401; 42CFR 435.301

Policy
If a pregnant woman does not meet the traditional income standard, her eligibility should be assessed using a household size increased by one, or the number of expected fetuses during the pregnancy in question. The unborn should not be added to the household size when a household is financially eligible without counting the unborn.

Note: Local WIC program staff are not required to implement this policy in those individual cases where increasing a pregnant woman's household size conflicts with cultural, personal, or religious beliefs.

Guidelines

A. Other Family Members
    1. In situations where the household size has been increased for a pregnant woman, the same increased household size may also be used for any of her categorically eligible family members

Policy Number: 5-4
Military Personnel Income
Effective/Revised Date: October 1, 1997

Military Personnel Income

Purpose
To ensure Local Agencies can determine eligibility of a military household.

Authority
7CFR Part 246.7

Policy
For WIC purposes, military personnel serving overseas or assigned to a military base, even though they are not living with their families, should be considered members of the economic unit. The income received by the military individual(s) and all other income received by members of the economic unit shall be counted as income to the household.

Note: The BAQ housing allowance is the only exception. This exclusion includes both off-base housing and payments for privatized on-base housing.

Guidelines

I. Exception to Income Documentation

Income must be documented. However, some military families, particularly those which include military service personnel serving overseas, may have difficulty producing a pay stub or other documentation of the gross military income. In these instances, the applicant may simply self-declare the family's military income to the best of his or her knowledge.

II. Rate of Income

A. If an active duty uniformed service member stationed in a designated high cost area is receiving either the CONUS or OCONUS COLAs, the amount must be included in determining WIC financial eligibility (see Federal Regulations 246.7(d)(2)).

B. If a family includes one or more members stationed overseas or away from home, the military may determine that they may receive additional military compensation, e.g., hazardous duty or combat pay, family separation allowance, and/or foreign duty pay. Such pay is provided on a temporary basis; therefore, agencies may elect to consider the family income during the past 12 months as a more accurate indicator of the family's income.

If one or more family members are military reservists who have been placed on active duty, some will experience dramatic changes in their income source(s) and total gross income so that they may become income eligible for the WIC Program. While the reservist is on active duty, determine such family's income eligibility based on the family's "current" rate of income, as opposed to income received over the past 12 months.

Note: The current rate of income is the income received by the household during the month prior to application.

III. In Temporary Care

A. Local programs may be confronted with dramatic household composition changes for military family members in which military service personnel are deployed overseas, temporarily absent from the home and military dependents may be in the temporary care of friends or relatives.

B. The most important rule to apply to all applicants, including minors, is that an economic unit must have its own source of income. Given this essential element, the local WIC program must then decide whether the income is adequate to sustain the economic unit.

1. Count the absent parent(s) and the child(ren) as the economic unit.

2. Count the children and/or remaining parent as a separate economic unit. The unit would have its own source of income (i.e., the dependent's allotment) and the determination would have to be made whether the income is adequate to sustain the economic unit. If the child allotments were not considered adequate (as defined by the State), option three would be used.

3. Consider the children to be part of the economic unit of the person(s) with whom they are residing.

Institutions and Homeless

Purpose

Guidance for Local Agency determination of Institutions and Homeless facilities.

Authority

PL 103-448; USDA Policy MPSF-1: WC-95-34-P; ARM 46.10.321; ARM 46.12.3401; 42 CFR 435.301; 7CFR.246.7(n)

Policy

The following are considered institutionalized or homeless individuals:

- A supervised publicly or privately operated shelter (including a welfare hotel, congregate shelter, or shelter for victims of domestic violence) designed to provide temporary living accommodations
- A facility that provides temporary residence for individuals intended to be institutionalized
- A temporary accommodation in the residence of another individual, or
- A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, may be eligible for WIC benefits

Guidelines

I. Assurances

A. In order for residents in a homeless shelter or institution to qualify for WIC benefits, the WIC program must be assured the facility complies with the following conditions:

1. The facility does not accrue financial or in kind benefit from a person's participation in the WIC Program, e.g., by reducing its expenditures for food service because its residents are receiving WIC foods.

2. Foods provided by the WIC Program are not subsumed into a communal food service, but are available exclusively to the WIC participant for whom they were issued.

3. The facility places no constraints on the ability of the participant to partake of the supplemental foods and nutrition education available under the WIC Program.

II. Responsibilities

The local WIC program is delegated authority to evaluate any homeless shelter or institution every two years to ensure it meets the above criteria. A written copy of the evaluation must be kept on file at the Local WIC Program. A homeless facility or institution shall notify the Local Program if it ceases to meet any of the above conditions.

HOMELESS SHELTER/INSTITUTION EVALUATION FORM

Name of facility/institution:

Address:

Phone Number:

Contact Person:

I understand that the facility will not accrue financial gain or in-kind benefit from a person's participation in the WIC program.	Contact person's signature:	Date:
I understand that foods provided by the WIC program may to be subsumed into a communal food service. The foods will be available exclusively to the WIC participant for whom they were issued.	Contact person's signature:	Date:
I understand that this facility will place no constraints on the ability of the participant to partake of the nutrition education and supplemental foods available under the WIC program.	Contact person's signature:	Date:
I understand that the intentional misuse of WIC foods by the facility may make me a party to fraud and may subject me to civil and criminal prosecution under State and Federal law.	Contact person's signature:	Date:

WIC staff signature: Date:

Foster Child Benefits

Purpose
To ensure Local Agencies obtain proper documentation when certifying a foster child

Authority
CFR 246.7 & State Policy

Policy
Local Agencies will serve foster children who are eligible for WIC program benefits.

Guidelines

I. Documentation

In order to serve a foster child, a clinic must have on file documentation of the placement of the child in foster care whether the child is in the care of a foster parent, protective services, or child welfare authorities.

II. Procedures

Please see Financial Eligibility # 5-24 for the procedures to use when serving a foster child.

Local Agency Employees as WIC Participants

Purpose
Guidance for certifying applicants who are Local Agency employees

Authority
State Policy

Policy
A Local Agency employee may also be a WIC participant.

Guidelines

I. Restrictions

A. A Local Agency employee eligible for WIC benefits shall not be the Local Agency's authorized CPA or issuer for her/his own, her/his children's or immediate family member's WIC checks.

Note: In the above situation, the supervisor must first obtain authorization from DPHHS/WIC to determine eligibility and/or issue WIC checks.

B. A supervisor must determine eligibility and/or issue the WIC checks for employees participating in WIC.

II. Documentation

A. Food instruments issued to an immediate family member, including grandchildren, of local agency staff shall be documented in the participant's file and this documentation made available during annual monitoring visits by State agency staff.

B. Local Agency employees may not act as proxies for family members or other participants.

Policy Number: 5-8
Access to WIC Services
Effective/Revised Date: October 1, 1997

Access to WIC Services

Purpose
To ensure Local Agencies offer WIC services and benefits to all potentially eligible persons in Montana.

Authority
State Policy

Policy
Citizens in Montana will have WIC services and benefits available to them.

Guidelines

I. WIC services and benefits will be offered to all potentially eligible persons in a manner consistent with State WIC policies, Federal regulations and applicable laws.

Policy Number: 5-9
Appointments
Effective/Revised Date: October 1, 1997

Appointments

Purpose
Guidance for Local Agencies in making appointments for WIC applicants

Authority
State Policy

Policy
An appointment system will be used in Local Agencies for the delivery of WIC benefits.

Guidelines

I. Background

A. A variety of office management systems are available to Local Agencies. However, experience based upon the analysis of patient flow in Montana WIC clinics shows that using a system of appointment-making is the most time efficient way to operate a WIC clinic. No appointments, or a “drop in” system, are not efficient.

1. Traditional Hours - The traditional hours for business appointments are 8:00 am to 12:00 pm and 1:00 pm to 5:00 pm, Monday through Friday.

2. Non-Traditional Hours - To provide access to WIC services for working, rural and student participants, local WIC agencies will make available appointments outside traditional hours.

II. Alternative Appointments

Example: Hours before 8:00 am, between 12:00 pm and 1:00 pm, after 5:00 pm and on Saturdays.

Policy Number: 5-10
Priorities Served
Effective/Revised Date: October 1, 1997

Priorities Served

Purpose

Guidance for Local Agencies to serve WIC priority I - VI participants

Authority

7 CFR 246.7 & State Policy

Policy

The Montana WIC Program will serve WIC Program Priorities I through VII.

Guidelines

I. Priority I
A pregnant woman, a breastfeeding woman or an infant in nutrition need as documented by hematological or anthropometric measurements or other medical conditions which demonstrate the person's need for supplemental foods.

II. Priority II
An infant whose mother was a WIC participant or was nutritionally eligible to be a WIC participant during her pregnancy or a breastfeeding woman of such an infant with neither having a Priority I Nutrition Risk Code.

BREASTFEEDING PAIR: The mother/infant is to be placed in the highest priority to which either is qualified. For a mother/infant to qualify as Priority II, the infant must have qualified first as a Priority II infant and therefore have been six (6) months of age or less at the time of certification. When this occurs, if the breastfeeding mother is a lower priority risk, she must be placed in Priority II along with her infant.

III. Priority III
A child in nutrition need as documented by hematological or anthropometric measurements, or other medical conditions which demonstrate the child's need for supplemental foods. A postpartum woman who was age 17 or younger at the time of conception.

IV. Priority IV
A pregnant woman, a breastfeeding woman, or an infant at nutrition risk because of inappropriate dietary practices for category and/or age, or in social situations which may impact nutritional status.

V. Priority V

A child at nutrition risk because of inappropriate dietary practices for age or in social situations which may impact nutritional status.

VI. Priority VI

A postpartum woman in nutrition need as documented by hematological or anthropometric measurements, other medical conditions, inappropriate dietary practices or in social situations which may impact nutritional status. (Exception: teen postpartum, 17 or younger at conception, see Priority III.)

VII. Criteria for Priority Assignment

The information contained in nutrition risk codes, Policy 5-12, constitutes the criteria for assignment in priority categories.

Policy Number: 5-11
Certification Periods
Effective/Revised Date: October 1, 1997

Certification Periods

Purpose
Guidance for Local Agencies to apply an appropriate certification period based on an applicants category

Authority
37-25.101, MCA; 7 CFR 246.7

Policy
Local agencies assess applicants for WIC benefits and if eligible, utilize the following time periods for receipt of program benefits:

If the category is…	Then the Certification Period is for...
Pregnant Women	The duration of their pregnancy and for up to six (6) weeks postpartum. **Note:** A 30-day extension may not be given.
Breastfeeding Women	Intervals of approximately six (6) months ending with the breastfeeding infant's first birthday. **Note:** A 30-day extension may not be given past the infants first birthday.
Postpartum Women (non-breastfeeding)	Up to six (6) months after termination of pregnancy. **Note:** A 30-day extension may not be given.
Infants (before 6 months of age)	Up to the date of his/her first birthday. **Note:** A 30-day extension may not be given for infants certified eligible to one year of age.
Infants (6 months of age and after)	Intervals of six (6) months (may be certified beyond first birthday).
Children	Intervals of six (6) months, up to the end of the month in which the child reaches their fifth birthday.

Guidelines

I. Women

A. Pregnant women shall be certified for the duration of their pregnancy and for up to six weeks postpartum, receiving one food package to begin being "good" after delivery but not valid beyond her six weeks postpartum date. They may not be given a 30-day extension.

B. Breastfeeding women shall be certified at intervals of approximately 6 months ending with the breastfeeding infants' first birthday.

C. Postpartum women (non-breastfeeding) may be certified for up to 6 months after termination of pregnancy.

D. Migrant and Priority I pregnant women must be given notice of eligibility or ineligibility within 10 days of the date of first request for benefits unless a written request for an extension to 15 days has been made and approved by the State WIC Agency. Expedited service is required.

II. Infants

A. Income must be verified and the Certification Form and Eligibility Statement completed. All aspects of a certification must be completed before WIC checks are issued (except hematological test if less than nine months of age).

B. Infants certified before 6 months of age are certified to the date of their first birthday. Length and weight and feeding tolerance shall be monitored monthly for the first 3 months of life, or for the first 3 months of certification if the infant is not certified shortly after birth. Beyond this first 3 months' monitoring, if growth is consistent and no feeding problems exits, growth and diet progression shall be monitored at least every 3 months. A test for anemia, such as a hemoglobin or hematocrit, shall be performed at 9 months of age. Premature and low birth weight infants not fed the equivalent of a full WIC food package of iron-fortified formula shall be screened at 6 months of age. Nutrition education contacts shall be provided at least quarterly.

C. If a nutrition risk code indicating a current or potential growth concern is documented (risk codes 10, 11,12, 13, 14, 15 and 17), growth (length and weight) must be monitored at least every two months (recommended every month) beyond the first 3 months' monitoring unless a consistent appropriate growth pattern has been documented on the growth grid.

D. Infants may not be certified as Priority II, with risk codes 23 or 24, after 6 months of age.

E. If certified Priority I or IV after 6 months of age, certifications will be at 6 month intervals (change Food Package at 1 year).

III. Children

A. Income must be documented and the Certification Form and Eligibility Statement completed. All aspects of a certification must be completed before WIC checks are issued

B. Children shall be certified at intervals of six (6) months and end at the end of the month in which the child reaches his/her fifth birthday.

C. If a nutrition risk code indicating a current or potential growth concern is documented (risk codes 10, 11,12, 13, 14, 15 and 17), growth (length and weight) must be monitored at least every two months (recommended every month).

IV. Physical Presence

A. Exception for Medical Reasons. Exception to the physical presence requirement may be made for applicants who meet the conditions noted below:

1. having a medical condition which necessitates the use of medical equipment which is not easily transportable;
2. having a medical condition which requires confinement to bed rest;
3. having a serious illness which may be exacerbated by coming into the clinic.

B. Exception for Working Parents/Caregivers. Exception to the physical presence requirement may be made for children if physical presence would present an unreasonable barrier to participation under the following circumstances if the child:

1. was present at the initial certification; AND
2. was present at a subsequent certification within the past year; AND
3. has two parents or two primary caregivers who both work during the time the local agency is open (if the child has two parents/caregivers) or has one parent or primary caregiver who works during the time the local agency is open (if the child has one parent or primary caregiver).

C. Documentation of Need for an Exception

1. Documentation must be provided when seeking an exception to the physical presence requirement when:
    a. seeking an exception for medical reasons - signed and dated documentation from a health care provider stating the medical condition is required.
    b. seeking an exception for working parents/caregivers - a statement from the parents/caregivers documenting their employment status and work hours is needed.

2. Documentation is only applicable to the certification period for which it was provided. Local agencies must maintain a copy of the documentation provided in the participant record.

D. All necessary information for certification required.

Although an applicant may be exempt from physical presence at certification, all necessary information for certification is required. This includes proof of identification, proof of residency, proof of income, anthropometric data and blood work data (when required).

V. 30-Day Extension. Extensions must be made before the termination date has been reached. Extensions should be a rare occurrence and the reason must be documented in the chart.

A. A 30-day extension for the certification interval may be permitted for breastfeeding women, children and infants who are certified for 6 months or less, (except transfers from out-of-state), for the following reasons only:

1. Participants are unable to be present at the normal certification date (i.e., due to illness or severe weather conditions.)
2. Local WIC program/participant/guardian requests certifications for all family members to occur at the same visit.
3. Local WIC program wishes to coordinate data collection with other programs, health professionals, etc.

Note: A 30-day extension is not allowed for infants certified to one year of age.

VI. Changes Due to Birthdays

A. An infant becomes a child at one year of age. However, he/she may have last been certified at 7, 8, 9, 10 or 11 months of age. There is no need to certify the child again at one year of age, but the food package must be changed to reflect the category change.

B. When a child turns five, a food package may be issued until the end of the month of his/her 5th birthday.

VII. Biochemical Tests

A. All pregnant applicants must have a hematocrit/hemoglobin screening performed for certification. Breastfeeding and postpartum applicants must have one screening after termination of pregnancy, ideally four to six (4-6) weeks postpartum. If the screening is above the established cut-off value for anemia, no additional test is required for a subsequent breastfeeding or postpartum certification following the same pregnancy. If the screening is at or below the established cut-off value for anemia, a hematocrit or hemoglobin test is required for a subsequent breastfeeding or postpartum certification following the same pregnancy unless the data is less than sixty days old.

B. For all children applicants, WIC clinic personnel must use the following requirements for a hematocrit/hemoglobin screening if the child is:

1. under the age of twenty-seven months at the date certification begins - a screening must be performed;

2. twenty-seven months old or older at the date certification begins and has not had a certification screening within the past seven months or had a certification screening within the past seven months in which the result was at or below the established cut-off value for anemia - a screening is required for certification.

3. twenty-seven months old or older at the date certification begins and had a screening at certification within the last seven months in which the result was above the established cut-off value for anemia, a screening need not be done for the current certification.

C. For all infants six (6) months of age or older, WIC clinic personnel must use the following requirements for a hematocrit/hemoglobin screening if the infant is:

1. fed the equivalent of a full WIC food package of iron-fortified formula and is:

a. between eight and one-half (8 1/2) months and nine and one-half (9 1/2) months of age - a screening must be done. If for any reason the infant misses or does not show up for the appointment scheduled during this time frame, a hematocrit/hemoglobin must be done before the checks are issued; or

b. applying for WIC and is eight and one-half (8 1/2) months or older - a screening must be done.

2. not being fed the equivalent of a full WIC food package of iron-fortified formula and is:

a. six or seven months of age and is defined by WIC nutrition risk codes as premature and low birth weight - a screening must be done; or

b. between eight and one-half (8-1/2) months and nine and one-half (9-1/2) months of age and not defined by WIC nutrition risk codes as premature and low birth weight- a screening must be done. If for any reason the infant misses or does not show up for the appointment scheduled during this time frame, a hematocrit/hemoglobin must be done before the checks are issued.

VIII. Hematocrit/Hemoglobin Follow-up

For all participants, if a hematocrit/hemoglobin screen is below the established cut-off value, a follow-up test must be performed during the next one to two months. Nutrition education related to iron sources, enhancers and inhibitors must also be

provided. Appropriate referrals should be made according to Policy 5-13 Designated Referrals form high risk WIC Participants.

IX. Valid Data

A. Anthropometric and biochemical data up to sixty (60) days old may generally be used for certification. The data must be reflective of a woman applicant's category (pregnant or breastfeeding/postpartum) at the date certification begins. Anthropometric and biochemical data collected on a pregnant woman may not be used to certify her as a breastfeeding woman as her category has changed. Biochemical data for pregnant women must also be reflective of the trimester of pregnancy in which the certification occurs.

B. The most current anthropometric data available should be used. Whenever possible, current weights and lengths of young infants should be used for certification rather than using birth weights and lengths. Hematocrit/hemoglobin levels used for certification of infants and children should be taken within the anemia screening schedule times as discussed above under "Biochemical Tests."

C. Data received from sources other than WIC must be in writing, signed and dated by the provider. A note of the source of the data must be made in the participant record.

X. Back-Up Documentation

A. Back-up documentation must be available in the WIC family folder for all identified risk factors, priority assignment and certification. This documentation may be either on forms provided by the state WIC agency, or in a manner approved by the state WIC agency.

B. This includes, but is not limited to:

1. evaluated nutrition history information (such as the 24 hour recall or Infant Nutrition Questionnaire);
2. accurately plotted appropriate-for-age growth grids;
3. accurately plotted appropriate pregnancy weight gain grids;
4. biochemical and health history information for certain pregnancy risk factors or feeding problems identified in infants or children.

Certification Criteria and Priority Assignment

Purpose

Local Agency guidance for assigning nutrition risk codes to WIC applicants

Authority

7 CFR 246 and State Policy

Policy

The nutrition risk codes and definitions in the attached Risk Codes table constitute the nutrition risk codes which identify nutrition eligibility.

Guidelines

****** Insert MT WIC Program Hemoglobin/Hematocrit Cutoff Values Table after the Nutrition Risk Code Table***

WIC NUTRITION RISK CODES

(Effective June 1, 2005)

Category/ Priority					Code	Description
P	B	N	I	C		
			1		10 * (142)	PREMATURITY Born at 37 weeks gestation. For infants and children 2 years of age at date of certification.
			1	3	11 * (141)	VERY LOW BIRTHWEIGHT AND LOW BIRTHWEIGHT Birth weight 5 pounds 8 oz. at birth (2500 gm). For infants and children 2 years of age at date of certification. Growth of VLBW infants may be monitored using Infant Health and Development Program (IHPD) charts in addition to the 2000 CDC Growth Charts.
			1	3	12 (134)	FAILURE-TO-THRIVE Presence of failure to thrive. The condition must be specified in the chart and diagnosed by a physician or by a health care provider. The applicant/participant/caregiver or someone working under a health care provider's orders may report the diagnosis.
			1	3	13 * (121)	SHORT STATURE 10th percentile length or height for age (based on 2000 CDC Growth Charts). For premature infants and children 2 years of age at date of certification, assignment of this risk criterion will be based on adjusted gestational age, once the infant has reached the equivalent age of 40 weeks gestation. Monitor the growth pattern with consideration of the family stature.
			1	3	14 (135)	INADEQUATE GROWTH An inadequate rate of weight gain as defined below: For Infants from birth to 1 month of age: Excessive weight loss after birth (> 1/2 lb or 8% lost from birth). Weight not back to birth weight by 3 weeks of age. For Infants from 1 month to 6 months of age: Based on 2 weights taken at least 1 month apart, weight gain less than calculated weight gain from Table A. For Infants and Children from 6 months to 59 months of age: Based on 2 weights taken at least 3 months apart but not more than 8 months

Category/ Priority					Code	Description
P	B	N	I	C		
						apart, weight gain less than expected weight gain from the table below. Age — Average Weight Gain 6 - 12 mo: 2 1/4 oz per wk; 9 1/2 oz per mo; 3 lbs 10 oz/6 mo 12 - 59 mo: 0.6 oz per wk; 2.7 oz per mo; 1 lb/6 mo
			1	3	15 * (103)	THINNESS ≤ 10th percentile weight for length for children less than age 2 years or ≤ 10th percentile Body Mass Index (BMI) for children age 2 years and older (based on 2000 CDC age/sex specific growth charts).
				3	16 * (114)	AT RISK OF BECOMING OVERWEIGHT A child age 2 years or older whose Body Mass Index (BMI) is ≥ 85th and < 95th percentile (based on 2000 CDC age/sex specific growth charts). NOTE: This item cannot be used for children ages 24-36 months with a disability which results in their being measured in a recumbent position. BMI may only be calculated using a stature measurement.
				3	17 * (113)	HIGH BODY MASS INDEX - CHILDREN A child age 2 years or older whose Body Mass Index (BMI) is ≥ 95th percentile (based on 2000 CDC age/sex specific growth charts). NOTE: This item cannot be used for children ages 24-36 months with a disability which results in their being measured in a recumbent position. BMI may only be calculated using a stature measurement.
			1	3	18 (151)	SMALL FOR GESTATIONAL AGE Presence of small for gestational age diagnosed by a physician or by a health care provider. The applicant/participant/caregiver or someone working under a health care provider's orders may report the diagnosis. For infants and children < 2 years of age at date of certification.
			1		19 * (153)	LARGE FOR GESTATIONAL AGE Birth weight ≥ 9 pounds (≥ 4000 gm). For infants ≤ 6 months of age at date of certification.
			2		23 * (701)	BORN TO A WIC MOTHER An infant < 6 months of age at date of certification whose mother was a Montana WIC participant during her pregnancy and whose participant record is in the certifying clinic.

Category/ Priority					Code	Description
P	B	N	I	C		
			2		24 (701)	BORN TO A POTENTIAL WIC MOTHER • An infant < 6 months of age at date of certification whose mother was NOT a Montana WIC participant during her pregnancy, but whose medical records document she was at nutritional risk during pregnancy because of detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally-related medical conditions, or • An infant whose mother was a Montana WIC participant during her pregnancy, but her participant record is not in the certifying clinic.
1	1	6	1	3	30 * (201)	LOW HEMATOCRIT/HEMOGLOBIN Hemoglobin or hematocrit concentration below the established cut-off value for healthy, well-nourished individuals of the same age, sex and stage of pregnancy. Adjustments for participant smoking and clinic altitude are considered in cut-off value determination. These cut-off values are provided in Table B for Women and Table C for Infants and Children.
1	1		1	3	37 (211)	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 10 µg/deciliter within the past 12 months.
1	1	3			41 * (331)	PREGNANT AT A YOUNG AGE Conception ≤ 17 years of age. Pregnant Women: Current pregnancy. Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy.
	1	3			42 * (111)	POSTPARTUM HIGH BODY MASS INDEX ≥ 25.0 Non-Breastfeeding Women: Prepregnancy BMI ≥ 25.0. Breastfeeding Women Who Are < 6 Months Postpartum: Prepregnancy BMI ≥ 25.0. Breastfeeding Women Who are ≥ 6 Months Postpartum: Current BMI ≥ 25.0.
1	1	6			43 * (332)	CLOSELY SPACED PREGNANCIES Conception < 16 months postpartum. Pregnant Women: Current pregnancy. Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy.
1	1	6			44 (333)	HIGH PARITY AND YOUNG AGE Under age 20 at date of conception with 3 or more previous pregnancies of at least 20 weeks duration, regardless of birth outcome.

Category/ Priority					Code	Description
P	B	N	I	C		
						Pregnant Women: Current pregnancy. Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy.
1					45 * (111)	PREGNANT HIGH BODY MASS INDEX 29.0 Pregnant Women: Prepregnancy Body Mass Index > 29.0.
1					46 (131, 132)	MATERNAL WEIGHT LOSS OR LOW WEIGHT GAIN DURING PREGNANCY Certification in the 1st trimester: Weight loss of 5 pounds. Certification in the 2nd and 3rd trimesters: Low weight gain such that the pregnant woman's weight plots beneath the bottom line of the appropriate weight gain range for her respective prepregnancy weight category (underweight, standard or overweight/obese). This may only be calculated using the prenatal weight gain grids supplied by the Montana WIC Program. For twin gestations, the recommended range of maternal weight gain is 35-45 pounds with a gain of 1.5 pounds per week during the second and third trimesters. Underweight women should gain at the higher end of the range and overweight women should gain at the lower end of the range. Four to six pounds should be gained in the first trimester. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week through out the pregnancy.
1	1	6			47 * (101)	LOW BODY MASS INDEX Pregnant Women: Prepregnancy Body Mass Index < 19.8. Non-Breastfeeding Women: Prepregnancy or Current Body Mass Index < 18.5. Breastfeeding Women Who are < 6 months Postpartum: Prepregnancy or Current Body Mass Index < 18.5. Breastfeeding Women who are 6 months Postpartum : Current Body Mass Index< 18.5.
1					48 * (111)	PREGNANT HIGH BODY MASS INDEX 26.1 AND 29.0 Pregnant Women: Prepregnancy Body Mass Index 26.1 and 29.0.
1	1	6			49 (133)	HIGH MATERNAL WEIGHT GAIN For Singleton Pregnancies: Pregnant Women: Current Pregnancy, all trimesters, all weight groups Weight gain 7 lbs/mo.

<table>
<tr><th colspan="5">Category/ Priority</th><th rowspan="2">Code</th><th rowspan="2">Description</th></tr>
<tr><th>P</th><th>B</th><th>N</th><th>I</th><th>C</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Breastfeeding/Nonbreastfeeding Women: Most recent pregnancy
Total gestational weight gain exceeding the upper limit of the recommended range based on Prepregnancy Body Mass Index (BMI), as follows:

<table>
<tr><th>Prepregnancy Weight Groups</th><th>Definition</th><th>Cut-off Value</th></tr>
<tr><td>Underweight</td><td>< 19.8 BMI</td><td>> 40 lbs</td></tr>
<tr><td>Normal Weight</td><td>19.8 to 26.0 BMI</td><td>> 35 lbs</td></tr>
<tr><td>Overweight</td><td>26.1 to 29.0 BMI</td><td>> 25 lbs</td></tr>
<tr><td>Obese</td><td>> 29.0 BMI</td><td>> 15 lbs</td></tr>
</table>

An upper limit on weight gain for multifetal pregnancies (twins, triplets, etc.) has not been definitively established. For twin gestations, the recommended range of maternal weight gain is 35-45 pounds with a gain of 1.5 pounds per week during the second and third trimesters. Underweight women should gain at the higher end of the range and overweight women should gain at the lower end of the range. Four to six pounds should be gained in the first trimester. In triplet pregnancies the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week through out the pregnancy.</td></tr>
<tr><td>1</td><td>1</td><td>6</td><td></td><td></td><td>50

(303)
(311)
(312)
(337)
(321)

(321)
(321)

(339)</td><td><u>PREVIOUS PREGNANCY COMPLICATIONS</u>

Previous obstetric history of one or more of the following:
<table>
<tr><td></td><td>Gestational diabetes.</td></tr>
<tr><td></td><td>Preterm Delivery: Infant born at 37 weeks gestation.</td></tr>
<tr><td></td><td>Low Birth Weight Infant: Infant birth weight 5 lb 8 oz (2500 gm).</td></tr>
<tr><td></td><td>Large for Gestational Age Infant: Infant birth weight 9 lb (4000 gm).</td></tr>
<tr><td>●</td><td>Two or More Spontaneous Abortions: Two or more spontaneous terminations of gestation at < 20 weeks gestation.</td></tr>
<tr><td></td><td>Fetal Death: Death at 20 weeks gestation.</td></tr>
<tr><td></td><td>Neonatal Death: Death within 28 days of birth, not including death due to accident, child abuse, murder or illness (unless complicated prematurity or birth defect).</td></tr>
<tr><td></td><td>Infant with a congenital or birth defect which current research links to inappropriate nutritional intake, (e.g., inadequate folic acid - neuro tube defects, cleft lip and palate; excess vitamin A - cleft lip and palate).</td></tr>
</table>
Pregnant Women: Any pregnancy
Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy.

Condition(s) must be specified in the chart.</td></tr>
</table>

1	1	6			53 (335)	MULTIFETAL GESTATION More than one (> 1) fetus in utero. Pregnant Women: Current pregnancy. Breastfeeding/Non-Breastfeeding Women: Most recent pregnancy.
1					54 (301) (302) (345)	PREGNANCY-INDUCED CONDITIONS Current presence of one or more of the following: • Hyperemesis Gravidarum: Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic. • Gestational Diabetes: Glucose intolerance that appears during pregnancy and then usually returns to normal after the pregnancy ends. • Pregnancy-Induced Hypertension: Usually a systolic blood pressure increase of ≥ 30 mmHg or a diastolic blood pressure increase of ≥ 15 mmHg from earlier values before 21 weeks gestation. Presence of condition(s) must be specified in the chart and diagnosed by a physician or by a health care provider. The applicant/participant/caregiver or someone working under a health care provider's orders may report the diagnosis.
1	1	6	1	3	55 (357)	DRUG NUTRIENT INTERACTION Use of prescription or over-the-counter drugs or medications that have been shown to interact with nutrient intake or utilization to an extent that nutritional status is compromised. Effect of compromise on nutritional status must be specified in the chart.
1	1				56 (371)	SMOKING TOBACCO IN PIPES OR CIGARS Any current daily smoking of tobacco in pipes or cigars.
1	1				57 * (371)	CIGARETTE SMOKING Any current daily smoking of tobacco cigarettes.
1	1	6			58 * (372)	ALCOHOL USE Pregnant Women: Any alcohol use. Breastfeeding/Non-Breastfeeding Women: • Routine current use of ≥ 2 drinks per day. Routine is considered 2 or more (≥ 2) days per week. A standard sized drink is: 1 can of beer (12 fluid oz), 5 oz wine, or 1 1/2 fluid oz liquor (1 jigger), or • Current binge drinking of 5 or more (≥ 5) drinks on one or more (≥ 1) occasion(s).

1	1	6			59 (372)	OTHER DRUG USE Any street drug use; including marijuana, cocaine, crack, etc.
1	1	6	1	3	60 (341) (348) (362) (349) (350) (352) (353) (355)	NUTRITION-RELATED RISK CONDITIONS • Nutrient Deficiency Disease: Diagnosis of nutritional deficiency or a disease caused by insufficient dietary intake of macro or micro nutrients, e.g., protein energy malnutrition, scurvy, rickets, osteomalacia. • Central Nervous System Disorder: Condition which affects energy requirements and may affect the individual's ability to feed self. The condition must have an impact on nutritional status. Includes epilepsy (with uncontrolled seizures or use of the ketogenic diet), cerebral palsy and neural tube defects, Parkinsons disease and multiple sclerosis (MS). • Developmental, Sensory or Motor Delays: Developmental, sensory or motor disabilities that restrict the ability to chew or swallow food or require tube feeding to meet nutritional needs. These may include birth injury, head trauma, brain damage, minimal brain function, pervasive developmental disability (which may include autism) and feeding delays due to extreme prematurity. Document the interaction of the condition with nutritional status. • Genetic and Congenital Disorder: Hereditary or congenital condition at birth which alters nutritional status metabolically, mechanically, or both. Includes cleft lip or palate, Downs syndrome, thalassemia major, sickle cell anemia, and muscular dystrophy. • Pyloric Stenosis: Applies to Infants only. • Infectious Disease: A disease caused by growth of pathogenic microorganisms in the body, within the past six months, severe enough to affect nutritional status. Includes: tuberculosis, pneumonia, meningitis, parasitic infections, hepatitis, bronchiolitis - not bronchitis - (3 episodes in last 6 months), HIV (human immunodeficiency virus infection), and AIDS (acquired immunodeficiency syndrome). • Food Allergy: An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Not simple food intolerance, such as intolerance to strawberries, oranges, chocolate. This code may be used for an allergy to a food which is a significant component of one of the five major food groups of the Montana Food Guide Pyramid or is used as a pivotal ingredient in food preparation (wheat, eggs). • Lactose Intolerance: Documentation should indicate the amount of dairy-based products tolerated and the duration of the intolerance. Once the participant is age two or greater at date of certification, use of the code for this reason is limited to one (1) time as appropriate nutrition education should be provided during that time period. Presence of above condition(s) must be specified in the chart and diagnosed by a physician or by a health care provider. The applicant/participant/caregiver or someone working under a health care provider's orders may report the diagnosis.

1	1	6	1	3	60
					
					(359)
						NUTRITION-RELATED RISK CONDITIONS (continued)
						
						• Recent Major Surgery, Trauma, Burns: Surgery, trauma or burns severe enough to compromise nutritional status.
						  • Extensive surgery such as cardiac or gastro-intestinal surgery (not a C-section, tonsillectomy or appendectomy, unless associated with complications/infections) or multiple surgeries relating to the same condition occurring within several months.
						  • Fracture of arm, leg, or pelvis or fractures of several other large bones concurrently or fracture of the jaw which greatly limits food intake.
						  • Burns: Second degree burns which cover more than 30% of the body or third degree burns on the face or extremities or more than 10% of the body surface.
						
						Any occurrence within the past two (≤ 2) months may be self reported. More than two (≤ 2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician.

1	1	6	1	3	61	CHRONIC DISEASES
					(342)	Gastro-Intestinal Disorder: Disease or condition that interferes with the intake or absorption of nutrients. Includes: stomach or intestinal ulcers, small bowel enterocolitis and syndrome, malabsorption syndrome, inflammatory bowel disease (including ulcerative colitis or Crohn's disease), liver disease, pancreatitis, gallbladder disease and gastroesophageal reflux (GER) which results in inadequate weight gain.
					(343)	
					(344)	Diabetes Mellitus: Not including gestational diabetes (risk code #54).
					(346)	Thyroid Disorder: Hypothyroidism or hyperthyroidism which is untreated or unregulated.
					(347)	Renal Disease: Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder.
					(354)	Cancer: A chronic disease whereby populations of cells have acquired the ability to multiply and spread without usual biological restraints. Some nutrition problems that may be caused by the disease or disease treatment include anorexia, maldigestion, chewing and swallowing problems, and protein-calorie malnutrition.
					(360)	Celiac Disease: Also known as celiac sprue, gluten enteropathy, and non-tropical sprue.
						Other Medical Conditions: Other diseases or conditions with nutritional implications. Includes: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, and persistent asthma (moderate or severe) requiring daily medication. This criterion will not be applicable for infants for the medical condition of asthma.

1	1	6	1	3	61 (361)	CHRONIC DISEASES (continued) • Depression: Clinical depression which currently affects nutritional status through an effect on weight. Current condition(s), or treatment for the condition(s), must be severe enough to affect nutritional status. Documentation in the participant record must include the condition(s) and the clearly defined effect on nutritional status. Condition(s) must be diagnosed by a physician or by a health care provider. The applicant/participant/caregiver or someone working under a health care provider's orders may report the diagnosis.
1	1	6	1	3	62 (351)	INBORN ERRORS OF METABOLISM Presence of inborn error(s) of metabolism - genetic mutations or deletions that may have pathological consequences. Includes: galactosemia, tyrosinemia, homocystinuria, phenylketonuria (PKU), maple syrup urine disease, glycogen storage disease, histidinemia, urea cycle disorders, and hyperlipoproteinemia. Call one of the WIC State Nutritionists to discuss a possible disorder which may meet this definition. Presence of condition(s) must be specified in the chart and diagnosed by a physician or by a health care provider. The applicant/participant/caregiver or someone working under a health care provider's orders may report the diagnosis.
			1	3	64 (382)	FETAL ALCOHOL SYNDROME Fetal Alcohol Syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities, and abnormalities of the central nervous system, including mental retardation. Presence of FAS must be diagnosed by a physician or by a health care provider. The applicant/participant/caregiver or someone working under a health care provider's orders may report the diagnosis.
1	1	6		3	65 (381)	DENTAL PROBLEMS (EXCEPT EARLY CHILDHOOD CARIES) Diagnosis of dental problems, except early childhood caries. Includes: • Tooth decay, periodontal disease, tooth loss and/or ineffectively replaced teeth which impair the ability to ingest food in adequate quantity or quality (for children and all categories of women); and • Gingivitis of pregnancy (for pregnant women). Presence of Dental Problems must be diagnosed by a dentist, a physician, or a health care provider or be adequately documented by the Competent Professional Authority

						(CPA).
			1	3	66 (381)	EARLY CHILDHOOD CARIES Serious tooth decay, usually of the upper front teeth. Also known as Baby Bottle Tooth Decay. Restored Early Childhood Caries are not a risk. Code may be used only one (1) time for certification, as appropriate nutrition education should be provided during that time period. Presence of Early Childhood Caries must be diagnosed by a dentist, a physician, or a health care provider or be adequately documented by the Competent Professional Authority (CPA).
1	1	6			67 (358)	EATING DISORDERS Eating disorder symptoms are manifested by abnormal eating patterns which may include: self-induced vomiting; purgative abuse; alternating periods of starvation; use of drugs such as appetite suppressants, thyroid preparations, or diuretics for weight reduction; and self-induced marked weight loss. The disorder must currently be impacting nutritional status with the nutritional impact documented in the participant record. Presence of eating disorder(s) must be diagnosed by a physician, a psychologist or a health care provider. The applicant/participant/caregiver or someone working under a health care provider's orders may report the diagnosis.
	1				70 (601)	BREASTFEEDING MOTHER OF PRIORITY I INFANT A breastfeeding mother with nutrition risk codes in Priority IV or no nutrition risk of her own, but whose infant has at least one nutrition risk code in Priority I.
	2				71 (601)	BREASTFEEDING MOTHER OF PRIORITY II INFANT A breastfeeding mother with nutrition risk codes in Priority IV or no nutrition risk of her own, but whose infant has at least one nutrition risk code in Priority II.
	4				72 (601)	BREASTFEEDING MOTHER OF PRIORITY IV INFANT A breastfeeding mother with no nutrition risk of her own, but whose infant has at least one nutrition risk code in Priority IV.
			1		73 (702)	BREASTFEEDING INFANT OF PRIORITY I MOTHER A breastfed infant with nutrition risk codes in Priority II, Priority IV or no nutrition risk of her/his own, but whose mother has at least one nutrition risk in Priority I.

			4		74 (702)	BREASTFEEDING INFANT OF PRIORITY IV MOTHER A breastfed infant with no nutrition risk of her/his own, but whose mother has at least one nutrition risk code in Priority IV.
	1				75 (602)	BREASTFEEDING COMPLICATIONS (WOMEN) A breastfeeding woman with any of the following complications currently or within the past month: • Recurrent plugged ducts. • Mastitis (fever or flu-like symptoms with localized breast tenderness). • Flat or inverted nipples. A woman experiencing breastfeeding complications must be referred for lactation counseling and/or, if appropriate, to her health care provider.

			1		76
					
					(603)
						BREASTFEEDING COMPLICATIONS (INFANT)
						
						A breastfed infant with any of the following complications:
						• Breastfeeding Jaundice: An exaggeration of the jaundice observed in many healthy newborns. It usually peaks between 3 and 5 days of life, although it can persist longer. This type of jaundice is a common marker for inadequate breastfeeding. An infant may display the following symptoms: infrequent or ineffective breastfeeding, failure to gain appropriate weight, infrequent stooling with delayed appearance of yellow stools, and scant dark urine with urate crystals. This condition should not be confused with "breastmilk jaundice", the onset of which begins 5 to 10 days after birth, in which the stooling and voiding pattern is normal. Presence of breastfeeding jaundice must be identified by a health care provider or certified lactation consultant. It may be self reported.
						• Weak or Ineffective Suck (May be due to prematurity, low birth weight, birth defects or injury, sleepiness of the baby, nipple confusion, or physical/medical problems such as heart disease, respiratory illness, or infection.)
						• Repeated Difficulty Latching onto Mother's Breast (May be due to flat or inverted nipples, engorgement, incorrect positioning and breastfeeding technique, birth defect or injury, or delayed initiation of breastfeeding.)
						• Inadequate Stooling and/or Wet Diapers, as follows:
						  ◦ inadequate stooling (< 4 times/day for newborns, < 1 time/4 days for infants > 3 weeks).
						  ◦ less than 6 wet diapers per day.
						
						An infant with breastfeeding complications must be referred for lactation counseling and/or, if appropriate, to her/his health care provider.

1					78 (338)	PREGNANT WOMAN CURRENTLY BREASTFEEDING Pregnant woman currently breastfeeding an infant whose intake is solely or predominantly breastmilk.
			4		79 (418)	INFREQUENT BREASTFEEDING AS SOLE SOURCE OF NUTRIENTS The fully breastfed infant (not consuming solid foods) who is routinely taking: • < 8 feedings in 24 hours if < 2 months of age, or • < 6 feedings in 24 hours if ≥ 2 months of age.

			4	5	80 (411, 412, 413, 414, 419) (425)	<u>INAPPROPRIATE FEEDING PRACTICES</u> For an infant, routine use of any of the following: • Not feeding breastmilk or infant formula as the primary source of nutrients during the first 6 months of life or as the primary fluid consumed during the second 6 months of life. • Feeding goat's milk, sheep's milk, cow's milk (except in an infant formula as defined in Public law 96-369 - The Infant Formula Act of 1980), imitation milk or substitute milks in place of breastmilk or infant formula during the first year of life. • Addition of solid food(s) into the daily diet before 4 months of age. • Not using a spoon to introduce and feed early solids. • Providing no dependable source of iron after 6 months of age (e.g., breastmilk, iron-fortified infant formula, iron-fortified infant cereal, meats or oral iron supplements). • Feeding foods of inappropriate consistency, size or shape that put the infant at risk of choking. • Late introduction of solids; failure to introduce solids by 7 months of age. * • Not encouraging finger feeding by 9 months of age. * For a child under the age of 24 months at date of certification, the routine use of any of the following: • Feeding of 12 or more ounces of any fruit juice per day. • Feeding non-fat or reduced-fat milks as the primary milk source (unless medically indicated for a severely overweight child as per policy 8-2). • Feeding foods primarily of a pureed or liquid consistency. * • Not encouraging self-feeding by 1 year of age. * * These justifications apply only if the infant/child is developmentally correct for age. Documentation in the participant record must include the basis for code selection. The use of this code for a child is limited to one time per justification, as appropriate nutrition education should be provided during the time period.

4	4	6	4	5	81 (422)	INADEQUATE DIET 24 hour recall demonstrates intake of less than the minimum number of servings recommended in any one of the five major food groups for the appropriate category (i.e. pregnant, breastfeeding, toddler). The five major food groups are identified by asterisks on the Montana Food Guide Pyramid handouts.
			4	5	83 (419)	BEHAVIORS INCREASING EARLY CHILDHOOD DENTAL CARIES • Routinely using the bottle to feed liquids other than breastmilk, formula or water. This includes fruit juice, soda pop, gelatin water, corn syrup solutions, milk or milk substitutes and other sugar-containing beverages. • Allowing the infant or child to routinely sleep with a bottle containing anything other than water. • Allowing the infant or child to routinely use a bottle containing anything other than water without restriction (e.g., walking around with the bottle) or as a pacifier. • Failing to begin weaning from the bottle by one year of age or failing to complete weaning from the bottle by 14 months of age. Documentation in the participant record must include the basis for code selection. Code use is limited to one (1) time for certification, as appropriate nutrition education should be provided during that time period.
4	4	6	4	5	87 (421)	PICA Current or recent (within the past 30 days) routine ingestion of non-food items includes: clay, laundry starch, cornstarch, dirt, ashes, paint chips, large quantities of ice and baking soda.
4	4	6	4	5	90 (903)	FOSTER CARE Woman (pregnant, breastfeeding, non-breastfeeding) or infant/child who has entered the foster care system during the previous six months or moved from one foster care home to another foster care home during the previous six months.

4	4	6	4	5	91 (901)	RECIPIENT OF ABUSE Woman (pregnant, breastfeeding, non-breastfeeding) or infant/child who has been the recipient of battering or child abuse/neglect within the past 6 months. Abuse may be self-reported or as reported through consultation with or documented by a social worker, health care provider, or other appropriate personnel. Abuse must be well documented in the participant record and WIC staff must follow Montana State Law requiring the reporting of known or suspected child abuse or neglect.
4	4	6	4	5	92 (902)	WOMAN OR PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD Woman (pregnant, breastfeeding, or non-breastfeeding) or infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Individuals with one or more of the following criteria may be considered: • 17 years of age. • Mentally disabled/delayed and/or have a mental illness such as clinical depression (diagnosed by a physician or licensed psychologist). • Physically disabled. • Currently abusing alcohol or other drugs. Documentation in the participant record must include the condition and the impact it has on limiting nutritional intake.
4	4	6	4	5	93 * (801)	HOMELESSNESS Categorically eligible women, infants or children who meet the definition of a homeless person, see DEFINITIONS.
4	4	6	4	5	94 * (802)	MIGRANCY Categorically eligible women, infants or children who meet the definition of migrant farmworker, see DEFINITIONS.
1 4	1 4	3 6	1 2 4	3 5	95 • (502)	TRANSFER -- KNOWN PRIORITY A participant transferring from outside of Montana with a valid VOC card with the priority code specified as Priority I, Priority II, Priority III, Priority IV, Priority V or Priority VI.
1	1	3	1	3	96 • (502)	TRANSFER -- UNKNOWN PRIORITY A participant transferring from outside of Montana with a valid VOC card on which the priority code is not specified.

*Computer Generated Codes

• - Computer Generated Codes under certain conditions - may require additional information from CPA.

Code numbers in parenthesis represent the National Nutrition Risk Code

Designated Referrals for High-Risk WIC Participants

Purpose

Guidance for Local Agencies when providing WIC services to high-risk participants.

Authority

7 CFR 246 & State Policy

Policy

High-risk WIC Program participants shall be followed closely by the program CPA and referred to an appropriate service provider for assessment, intervention, counseling and follow-up.

Guidelines

I. Registered Dietitian

High risk participants must be referred to the Registered Dietitian on staff or under contract for development of nutrition education care plan, nutrition education (as appropriate), follow-up and monitoring.

II. Additional Service Providers

All participants should be referred to additional service providers, as appropriate, based on individual circumstances.

III. Follow-up

Follow-up must be provided on referrals made, preferably by the CPA. Referrals, follow-up and feedback must be documented in the participant file.

IV. Risk Code Referral Table

The information contained in the attached Table A High Risk Participant Referrals and the notes following it provide requirements for participant referral.

Table A - High Risk Participant Referrals

Code	Description	RD/LN	LC	HCP	DNT	SS/MHP
10	**PREMATURITY** All premature infants--RD will determine whether additional visits are necessary. Will refer to outside RD if nutrition risk factors 12, 14, 60 (nutrient deficiency disease, central nervous system disorder, developmental sensory or motor delays, genetic and congenital disorder, pyloric stenosis, infectious disease, food allergy, or recent major surgery, fracture or burn), 61, 62 or as determined necessary. With feeding difficulties or problems with weight gain. In addition, if breastfeeding.	X	 X	 X		
11	**LOW BIRTHWEIGHT** All low birth weight infants--RD will determine if additional visits are necessary. Will refer to outside RD if nutrition risk factors 12, 14, 60 (nutrient deficiency disease, central nervous system disorder, developmental sensory or motor delays, genetic and congenital disorder, pyloric stenosis, infectious disease, food allergy, or recent major surgery, fracture or burn), 61, 62 or as determined necessary. With feeding difficulties or problems with weight gain. In addition, if breastfeeding.	X	 X	 X		
12	**FAILURE-TO-THRIVE** All with diagnosis. Will refer to outside RD. In addition, if breastfeeding.	X	 X			
13	**SHORT STATURE** If growth velocity is decreasing. Will determine if	X		X		

	additional visits are necessary.					
Code	**Description**	**RD/LN**	**LC**	**HCP**	**DNT**	**SS/MHP**
14	**INADEQUATE GROWTH** If growth pattern does not improve upon recheck. RD will determine on a case-by-case basis whether to refer to outside RD. In addition, if breastfeeding.	X	 X	X		
15	**THINNESS** If growth velocity is decreasing. RD will determine on a case-by-case basis whether to refer to outside RD. In addition, if breastfeeding.	X	 X	X		
17	**HIGH WEIGHT FOR LENGTH/HEIGHT** If growth velocity is increasing. RD will determine on a case-by-case basis whether to refer to outside RD. In addition, if breastfeeding.	X	 X	X		
30	**LOW HEMATOCRIT/HEMOGLOBIN** If not at or above the established cut-off value upon recheck.	X		X		
41	**PREGNANT AT A YOUNG AGE** If conception is within 3 years after menarche.	X				
45	**HIGH BODY MASS INDEX > 29.0** Pregnant Women--If participant requests assistance with weight gain in appropriate range based on prepregnancy weight. Breastfeeding and Postpartum Women--If interest in assistance with weight reductition is stated. Refer to outside RD if requesting specific weight loss plan.	X X				
46	**MATERNAL WEIGHT LOSS OR LOW WEIGHT GAIN DURING PREGNANCY** All with risk factor at certification and any pregnant woman who fails to gain 2 pounds per month in the 2nd and 3rd trimesters.	X		X		

Code	Description	RD/LN	LC	HCP	DNT	SS/MH P
48	**HIGH BODY MASS INDEX > 26.1 AND ≤ 29.0** Pregnant Women--If participant requests assistance with weight gain in appropriate range based on prepregnancy weight. Breastfeeding and Postpartum Women--If interest in assistance with weight reductition is stated. Refer to outside RD if requesting specific weight loss plan.	X X				
49	**HIGH MATERNAL WEIGHT GAIN** Pregnant Women--all who gain more than 7 pounds per month. Breastfeeding and Postpartum Women--If interest in assistance with weight reduction is stated. Refer to outside RD if requesting specific weight loss plan.	X X		X		
50	**PREVIOUS PREGNANCY COMPLICATIONS** All women with a history of gestational diabetes. All pregnant women with a history of having a premature or low birthweight infant.	X X		X X		
53	**MULTIFETAL GESTATION** All pregnant or breastfeeding women.	X				
54	**PREGNANCY-INDUCED CONDITIONS** All women with hyperemesis gravidarum. RD will decide on a case-by-case basis whether to refer to outside RD. All women with gestational diabetes. Refer to outside RD for Medical Nutrition Therapy.	X X				

Code	Description	RD/LN	LC	HCP	DNT	SS/MH P
60	**NUTRITION-RELATED RISK CONDITIONS** All participants--Refer those not currently under the care of an outside RD to one, with the exception of those diagnosed with lactose intolerance or indicated to have had recent major surgery, trauma or burns. These will be referred on a case-by-case basis.	X				
61	**CHRONIC DISEASES** All participants--Refer those not currently under the care of an outside RD to one.	X				
62	**INBORN ERRORS OF METABOLISM** All participants--Refer those not currently under the care of an outside RD to one.	X				
64	**FETAL ALCOHOL SYNDROME** All participants. If having feeding difficulties or problems with weight gain.	X		 X		
65	**DENTAL PROBLEMS (EXCEPT EARLY CHILDHOOD CARIES)** At CPA discretion if one or more food groups is being eliminated.	X			X	
66	**EARLY CHILDHOOD CARIES**				X	
67	**EATING DISORDERS** All participants--Refer those not currently under the care of an outside RD to one. If eating disorder symptoms affect dental health.	X		X	 X	X
75	**BREASTFEEDING COMPLICATIONS (WOMEN)**		X			
76	**BREASTFEEDING COMPLICATIONS (INFANT)** All infants. In addition, with breastfeeding jaundice, a weak or ineffective suck, or presence of inadequate weight gain indicators.		X	 X		

Code	Description	RD/LN	LC	HCP	DNT	SS/MHP
78	**PREGNANT WOMAN CURRENTLY BREASTFEEDING** All pregnant women.	X				
79	**INFREQUENT BREASTFEEDING AS SOLE SOURCE OF NUTRIENTS** At CPA discretion, if accompanied by poor weight gain.	X				
80	**INAPPROPRIATE FEEDING PRACTICES** Infants not being fed breastmilk or infant formula as the primary source of nutrients during the first 6 months of life or as the primary fluid consumed during the second 6 months of life or infants not being provided with a dependable source of iron after 4 months of age.	X		X		
87	**PICA** All participants--RD will decide on a case-by-case basis whether to refer to outside RD.	X		X		
91	**RECIPIENT OF ABUSE**					X
92	**WOMAN OR PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD**					X
93	**HOMELESSNESS**					X
95/96	**TRANSFER**	Refer as appropriate for known or determined risk factors.				
No Code	**DIET** Participants who are following a therapeutic or a highly restrictive diet **or** who have made recent dramatic dietary changes (ex. traditional American to vegan vegetarian)--RD will decide on a case-by-case basis whether to refer to outside RD.	X				

Code	Description	RD/LN	LC	HCP	DNT	SS/MHP
No Code	**SPECIAL FORMULA** If not currently being followed:					
	Infants on special formulas other than Enfamil AR LIPIL, Nutramigen LIPIL, Alimentum or Pregestimil.	X				
	Children and Women with first authorization at one year of age or older on all special formulas, or with formula changes.	X				

Legend

RD/LN - Registered Dietitian/Licensed Nutritionist

LC - Lactation Counselor, preferably a Lactation Consultant when one is available

HCP - Health Care Provider

DNT - Dental Services

SS/MHP - Social Services or Mental Health Care Provider

Policy Number: 5-14
Participant Records
Effective/Revised Date: October 1, 1997

Participant Records

Purpose

To ensure Local Agencies are obtaining and maintaining accurate information for certification and reporting purposes

Authority

State Policy

Policy

Both an electronic and a hard copy of each participant's WIC records will be maintained at each local program. Each record (electronic and hard copy) must be a mirror image of each other (e.g., the computer screens must be completed using the exact information received in paper form for each certification or subcertification).

Guidelines

I. Electronic copy

The electronic copy is defined as the information collected and maintained by local programs utilizing the WIC automated system software on equipment provided by WIC.

II. Hard copy

The hard copy is defined as information written or printed on paper and/or forms which is collected and maintained by local programs. It may include, but is not limited to, information printed from data maintained in the WIC automated system.

III. Confidentiality

WIC participant records are medical records and consequently subject to confidentiality laws and rules. See Policy 4-11 Confidentiality for more information.

IV. Organization of WIC Chart Information

A. **Chart Information**

1. WIC charts in local clinics are exclusively WIC. The chart must contain the necessary documents to validate certification. An efficient arrangement is to assemble the administrative/financial documents on the left-hand side and the nutrition/health records on the right-hand side. Nutrition and health records should be grouped within a family chart by each individual participant. Listed below is suggested chart arrangement:

   a. Left-Hand Side:

      1. Certification Form and Eligibility Statement documenting financial and nutrition eligibility, signed and dated.

2. Participant's Responsibility Form (required as of January 1, 1996).
3. Release of Information signed and dated (if needed and specific). General Release of Information forms may not be used.
4. WIC Fair Hearing information

b. Right-Hand Side:

1. Prenatal Weight Gain Grid with measurements recorded and plotted.
2. Infant/Child Growth Grid with measurements recorded and plotted.
3. 24-hour Recall or Nutrition History
4. Medical history information for identified risk factors.
5. Nutrition Education Checklist/Progress notes.
6. Documentation of follow-up on referrals. Include name of the provider the participant has been referred to and the reason for the referral.

Policy Number: 5-15
Universal Precautions
Effective/Revised Date: October 1, 1997

Universal Precautions

Purpose

Provide guidance to Local Agency personnel whose duties involve participant contact or contact with blood or other body fluids in a health care setting

Authority

State Policy

Policy

Universal precautions (procedures to prevent spread of disease through contact with infective blood or body fluids) shall be consistently used for all WIC participants by WIC staff, including students, trainees, and volunteers, whose activities involve participant contact or contact with blood or other body fluids from participants in a health care setting.

Note: Local WIC program staff must follow those procedures established by the employer or the following, whichever is more restrictive.

Procedures

I. Caution

If a needle stick injury occurs, the injured person must be evaluated to determine if hepatitis prophylaxis is needed or human immunodeficiency virus is a concern. Report all needle stick injuries in accordance with your employer's policies and procedures.

II. Protective Clothing

A. If soiling with blood or body fluids, or contact with mucous membranes or non-intact skin is likely:

1. Gowns must be used to cover clothes-
   a. Wear gown only once
   b. Launder or discard if disposable
   c. Plastic aprons may be used instead. Changing or cleaning of the apron between participants is necessary.
2. Single-use gloves must be used if:
   a. Items or surfaces soiled with blood or body fluids will be handled, including capillary tubes and micro-cuvettes
   b. Venipuncture and other vascular access procedures (such as finger pricks for hematocrit or hemoglobin testing) will be performed.

Note: Gloves are for single use only. A new pair of gloves is required for each different participant and must be discarded in a manner that will prevent contact with the soiled gloves.

III. Hand Washing

A. Hands must be washed with warm soapy water, if available, or disposable towelettes:

1. Before gloving
2. Immediately after gloves are removed
3. If they are possibly contaminated with blood or body fluids
4. Before touching another person

B. Safety Goggles

1. Safety goggles must be worn when performing hematocrit/hemoglobin tests

C. Disposal

1. Articles contaminated with blood or body fluids must be properly discarded or reusable articles disinfected. Place contaminated materials in appropriately labeled containers and bags. Make arrangements for incineration in an approved facility if your employer does not currently have arrangements in place.
2. Without recapping, disposable sharp items must be placed in a prominently labeled, puncture resistant container for proper disposal. The container should be located as closely as practicable to the use area, but out of the reach of children.

D. Blood Spills

1. Blood spills must be cleaned up promptly with a solution of 5.25% sodium hypochlorite diluted 1:10 with water by a person wearing single use gloves. Example: One part regular Chlorox or Purex bleach in ten parts water.

2. Soiled towels, etc., used to clean the spill must be discarded in a manner that will prevent subsequent contact with them.

E. Pregnant Health Care Worker

1. Pregnant health care workers are not at a greater risk than other health care workers; however, if HIV infection occurs during pregnancy, the infant/fetus is at risk of infection from perinatal transmission. For this reason, pregnant health care workers should be especially familiar with and strictly adhere to this Policy.

F. Workers with Injuries

1. No health care worker who has an exudative lesion or weeping dermatitis in an area likely to be touched may directly care for a patient or handle patient-care equipment.

G. More Prevention

A. The following procedures will help prevent enteric disease transmission if diapers need changing during the WIC office visit.

1. Gowns must be used to cover clothes-
   a. Wear gown only once
   b. Launder or discard if disposable
   c. Plastic aprons may be used instead. Changing or cleaning of the apron between participants is necessary.

B. Single-use gloves must be used if:

1. Infective materials (feces and urine) will be handled

Note: Gloves are for single use only. A new pair of gloves is required for each different participant and must be discarded in a manner that will prevent contact with the soiled gloves.

C. Hands must be washed with warm soapy water, if available, or disposable towelettes:
   1. after touching the participant
   2. after touching potentially contaminated articles
   3. before touching another person

D. Change the Diaper(s).

1. The infant's care giver may change the diaper(s). If environmental contamination occurs as a result of the diaper change, procedures for clean-up described in Blood Spills (above) shall be followed.

Policy Number: 5-16
WIC Overseas Program
Effective/Revised Date: October 1, 2001

WIC Overseas Program

Purpose

To provide guidance to Local Agencies when a participant with a valid WIC Overseas VOC card applies for WIC benefits at their clinic.

Authority

7 CFR 246

Policy

Any WIC Overseas Program participant who returns to the U.S. with a valid WIC Overseas Program Verification of Certification (VOC) card must be provided continued participation in USDA's WIC Program until the end of his/her certification period, assuming the Local Agency is not at its maximum caseload.

Guidelines

I. Maximum Caseload/ Waiting List

A. If the Local Agency is at maximum caseload and has a waiting list for participation, transferring participants must be placed on the waiting list ahead of all waiting applicants regardless of the priority of their nutrition risk criteria.

II. Issuance of WIC VOC Cards

A. Local Agencies must issue WIC VOC cards to WIC participants affiliated with the military who will be transferred overseas. WIC clinics are not responsible for screening and determining eligibility for WIC Overseas Program eligibility.

B. WIC participants issued VOC cards when they transfer overseas must be instructed the following:

1. There is no guarantee the WIC Overseas Program will be operational at the overseas site where they will be transferred;
2. By law only certain individuals are eligible for the WIC Overseas Program; and
3. Issuance of a WIC VOC card does not guarantee continued eligibility and participation in the WIC Overseas Program. Eligibility for the overseas program will be determined at the overseas WIC service site.

C. Importance of WIC

1. Local Agencies should also emphasize to WIC clinic staff the importance of completing all information on the VOC card as the WIC Overseas Program personnel cannot readily contact a WIC Program to obtain further information.

D. All VOC cards must contain:

1. Name of the participant
2. Date the certification was performed
3. Date income eligibility was last determined
4. Nutrition risk conditions of the participant special emphasis is placed on specifying the nutritional risk conditions on the VOC card and avoiding the use of codes.
5. The date the certification period expires
6. The signature and printed or typed name of the certifying local agency official
7. The name and address of the certifying local agency
8. Identification number or some other means of accountability

III. Acceptance of WIC Overseas Program VOC Cards

A. Local Agencies must accept a valid WIC Overseas Program VOC card presented at a WIC clinic by WIC Overseas Program participants returning to the U.S. from an overseas assignment.

B. The following information on the card is absolutely essential:

1. The participant's name; the date the participant was certified; and the date the current certification period expires.

C. WIC Overseas Program participants arriving in a WIC clinic and showing a VOC card with only these three pieces of information should be treated just as if the VOC card contains all of the required information.

Collection of Race and Ethnicity Data

Purpose

To ensure that race and ethnicity data is collected to be used by Food and Nutrition Service (FNS) to determine how effectively the Program is reaching minority groups, and identify areas where additional outreach is needed. The state agency (SA) shall make use of such data for its internal civil rights monitoring.

Authority

USDA FNS Instructions 113-2, Rev. 1; 7 CFR Part 246.8

Policy

The local agency (LA) staff shall, at the time of certification, collect participation data by race and ethnicity category for each participant on the Program.

Procedures

I. LAs shall ensure that actual participation data by category of women, infants and children and by race and ethnicity category is collected and entered into the Montana WIC computer system.

II. Participants shall be reported in one or more racial categories and include: 1) American Indian or Alaska Native, 2) Asian, 3) Black or African American, 4) Native Hawaiian or Other Pacific Island and 5) White. See guidelines for definition of each category.

III. Participants shall be reported in only one ethnic category, “Hispanic or Latino” and “Not Hispanic or Latino”. See guidelines for definition of each category.

IV. Self-identification by the participant at the time of certification is the preferred method of obtaining data. Participants shall be asked to self-identify their racial and ethnicity group only after it has been explained, and they understand, that the collection of this information is strictly for statistical reporting requirements, and has no effect on the determination of their eligibility to participate in the program.

V. If a participant chooses not to self-identify her/his racial and/or ethnicity group, visual identification by a LA staff member must be used to determine the participant’s racial and ethnicity categories. Selection of one race is acceptable when LA staff performs visual identification.

VI. Analysis of this data will be used by the United States Department of Agriculture (USDA) and the SA to monitor compliance with Federal civil rights laws and to determine how effectively the Program is reaching minority groups and identify areas where additional outreach is needed.

Guidelines

I. Race

American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachments.

Asian. A person having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black.”

Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White. A person having origins in any of the original peoples of Europe, Middle East, or North Africa.

II. Ethnicity

Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin,” can be used in addition to “Hispanic or Latino.”

Search and Inquiry System (SIS) for Adjunctive Income Verification

Purpose

To ensure that Local Agency (LA) staff verify and document current adjunct or automatic income eligibility (AAIE) at participant certifications. LA verification of adjunct eligibility will create an audit trail which the State Agency (SA) will use for monitoring purposes.

Authority

USDA FNS 7 CFR Part 246.7, Montana WIC State Plan, Chapter 5

Policy

The LA staff shall verify and document the current AAIE of any WIC Program applicant claiming AAIE at their certification appointment.

Procedures

I. Procedures for LAs to access the SIS are in the attached Quick Reference and as per instructions given at the Spring Public Health Meeting (2005).

II. Adjunct eligibility must be verified for the month of certification. Adjunct eligibility can be verified prior to the appointment and applicants do not need to be present during the verification.

III. LAs will document the results from the SIS on the Certification Form and Eligibility Statement (CFES) as per the following examples:

Cert. Date	Income Source	Document Number(s)	Date of Document(s)
Date of "C"	Medicaid	Participant Number	Date of Verification or
Date of "C"	Food Stamps	Participant Number	Date of Verification or
Date of "C"	TANF	Participant Number	Date of Verification

On the CFES, WIC staff must document the certification date, the income source (i.e., Medicaid or FS or TANF, the document number(s) (i.e., whose participant # did you assign to your query at the time of verification), the date of document(s) (i.e., the date the verification was done).

V. All AAIE eligible participants must have their eligibility verified via the SIS (or via paper documents). Verification via SIS will leave the required audit trail.

Guidelines

I. If an applicant will be claiming AAIE at a certification appointment, LAs will determine which household member(s) to verify using SIS (or via paper documents).

II. If the applicant is a pregnant woman or an infant and their current Medicaid AAIE status is YES, any household member applying for WIC would be determined financially eligible. Each WIC applicant in the household must be confirmed in the SIS screen to document income verification and create an audit trail.

III. If the applicant is a breastfeeding woman, postpartum woman or child and their current Medicaid AAIE status is YES, only they would be determined financially eligible for WIC

IV. If the applicant, or a member of the household, is eligible to receive food stamps or temporary assistance for needy families (TANF) and their current AAIE status is YES, they would be determined financially eligible for WIC. Each WIC applicant in the household must be confirmed in the SIS screen to document income verification and create an audit trail.

V. If a participant informs your office of any change in circumstance (AAIE, financial, household size, etc.), which would effect WIC eligibility, the LA must follow-up on that information.

Policy Number: 5-19
Barriers to Providing WIC
Effective/Revised Date: October 1, 2005

Purpose
To provide guidance to Local Agencies in removing barriers to WIC services.

Authority
State Policy

Policy
The first priority of WIC staff is to provide WIC program services to the participants who come to the clinic. Participant service is the first priority, outranking paperwork, cleaning and miscellaneous tasks.

I. **Barriers to Service**

A. Since it is the role of the Montana WIC Program to serve the women, infants and children of this State, we must nurture the service aspect of the WIC Program.

B. Barriers exist which impact peoples' decision to apply for WIC. These barriers can be attitudinal, administrative and/or physical.

II. **Attitudinal Barriers**

A. Barriers may be the applicant's perception of WIC or the WIC staff's perception of the participant.

B. A potentially eligible participant may be reluctant to apply for WIC benefits because of a belief that the WIC Program is only for those "on welfare," that it "isn't for me, I can take care of myself," or other misconceptions. Also, many people not already involved in other social programs simply do not know about WIC. Outreach campaigns must target "reluctant" potentially eligible applicants.

C. Staff attitudes about participants they perceive to be unworthy or undeserving of WIC benefits set up barriers. It is easy to lose sight of our purpose to deliver quality nutrition education and counseling, intervention, referral and follow-up on identified risks, and improving eating behaviors and reducing or eliminating nutrition problems if we don't feel appreciated. Staff orientation and in-service training must deal with morale, keeping sight of WIC goals and the service philosophy.

III. Administrative Barriers

A. Be aware that improper use of the things that make your daily work more convenient for you may appear to be barriers to your participants.

1. A telephone answering machine can help to organize your day, but it may also reduce your effectiveness, especially if it is in use on the days your clinic is open. Remember many WIC participants do not have easy access to telephones.
2. Standard working hours of 8-12, 1-5 can be a formidable barrier for working or rural applicants. The availability of appointments before 8:00 a.m., from 12:00 to 1:00 p.m., after 5:00 p.m. and/or on weekends can provide access for participants not able to take time off from work or who have long distances to travel.
3. Multiple month food instrument issuance, when appropriate, is one way to service working or rural participants as long as the nutrition education component is not compromised. Additional sites should be considered as a way of serving rural residents, particularly if there are a number of potential participants unable to reach present services.
4. If you have a population of persons who speak a language other than English, an interpreter is crucial. Coordination with other WIC Programs is critical to the delivery of WIC benefits to the varied groups of people represented in Montana.
5. Coordination with other programs which target the same population as WIC is important too. The idea of “one-stop-shopping” is significant when trying to remove barriers to service. Coordination of appointments is invaluable to a person with limited resources and limited time to spend away from a job.

IV. Physical Barriers

A. Access to your clinic by pregnant women and those participants with physically disabling conditions is critical to WIC services.

1. The size, as well as the layout of your office, can contribute to barriers to service. The nature of the WIC Program dictates that much of the information discussed is of a personal and perhaps sensitive nature. If your office layout or location does not allow for a private discussion of these matters, a potential applicant may choose not to participate.
2. While it may not be feasible to immediately remodel or relocate your offices to have more accessible/appropriate facilities, it is necessary to modify procedures to service applicants/participants who cannot come to you. Modification of procedures may include going downstairs to hand a participant her WIC checks, enlisting the services of the county nurse to make a home visit to do a certification, holding education sessions at the local library instead of upstairs in your office, or finding a private area in which to interview participants (even if it means losing the coffee room or the broom closet).

V. Federal Regulations

A. The following is adapted from ADA Highlights, Title III, “Public Accommodations and Commercial Facilities.”

1. The Montana WIC Program will provide services in an integrated setting, unless separate or different measures are necessary to ensure equal opportunity. WIC will eliminate unnecessary eligibility standards or rules that deny individuals with disabilities an equal opportunity to enjoy WIC services. WIC will make reasonable modifications in policies, practices and procedures that deny equal access to individuals with disabilities.
2. In providing goods and services, WIC may not use eligibility requirements that exclude or segregate individuals with disabilities, unless the requirements are necessary for the operation of WIC.
3. For example, requiring that a disabled individual come to an inaccessible office to be certified for participation would violate the requirement.
4. Safety requirements may be imposed only if they are necessary for the safety of the applicant/participant. They must be based on actual risks and not on mere speculation, stereotypes or generalizations about individuals with disabilities.
5. WIC will make reasonable modifications in its policies, practices and procedures in order to accommodate individuals with disabilities. Legitimate safety requirements will be considered in determining what is readily achievable so long as they are based on actual risks and are necessary for safe operation.
6. Examples of modifications to remove barriers include installing ramps, making curb cuts at sidewalks and entrances, rearranging tables, chairs, display racks and other furniture, widening doorways, installing grab bars in toilet stalls, arranging for the services of a person familiar with sign language to assist in

serving deaf applicants/participants, and/or adding raised letters or Braille to elevator control buttons.

7. First priority should be given to measures that enable individuals with disabilities to "get in the front door," followed by measures to provide access to areas providing services. Barrier removal measures must comply, when readily achievable, with the alteration requirements of the ADA Accessibility Guidelines. If compliance with the Guidelines is not readily achievable, other safe, readily achievable measures must be taken.
8. WIC requires the removal of physical barriers, such as stairs, if it is readily achievable. However, if removal is not readily achievable, alternative steps must be taken to make services accessible. Examples of alternative measures include providing services at the door, sidewalk or curb, providing home services, relocating activities to accessible locations, including check pickup services and nutrition education classes.
9. Based on the Americans with Disabilities Act's accessibility guidelines for new construction and alterations, relocation, WIC clinics must be located in sites with:
    a. Disabled accessible parking,
        1. Accessible routes,
        2. Ramps, stairs, elevators,
        3. Doors, entrances,
        4. Bathrooms, alarms, signs and fixed seating.
10. The public or common use bathroom must be accessible.
11. Each floor in a building must also contain an "area of rescue assistance" (i.e., an area with direct access to an exit stairway where people unable to use stairs may await assistance during an emergency evacuation).
12. One TDD must be provided inside any building that has four or more public pay telephones. If no accessible public phone is provided, the WIC office will allow disabled participants use of the office phone for WIC related calls (e.g., an appointment call for referral services).
13. An annual, written assessment of each WIC clinic's physical layout must be performed by the Local WIC Program and kept on file at the clinic. If physical barriers are present, a plan of action must be written and submitted to the State WIC Office describing those measures which will be implemented to provide services to any disabled applicant/participant.

Policy Number: 5-20
Migrant Farmworkers/Native Americans/Homeless
Effective/Revised Date: October 1, 2005

Migrant Farmworkers/Native Americans/Homeless

Purpose

Guidance to Local Agencies providing WIC services to Migrant Farmworkers, Native Americans and Homeless individuals.

Authority

State Policy

Policy

Responsibility for the provision of program benefits to migrant farmworkers, Native Americans and homeless individuals are delegated to local programs. Any special clinics (such as evenings) or needs (such as interpreters) are to be arranged by local programs in accordance with their own community needs and the work season. The State WIC Agency offers technical assistance upon request.

Migrant workers who present current and official Verification of Certification (VOC) cards will be issued WIC checks at local WIC offices in Montana.

I. Local Program Responsibilities

A. Each local WIC program's designated representative shall examine the VOC card and determine the applicant's eligibility.

B. In each case, the local WIC program shall record the issuing agency's name, address and phone number. This information must be placed in the applicant's file folder.

C. Immediately return the VOC card to the applicant.

D. Issue a VOC card to migrants upon certification.

E. Identification must be verified before completion of the certification. This should not constitute a barrier to services. Refer to Policy 5-21 Application-Certification.

F. Migrant farm workers who meet the categorical, nutrition risk and income standards are eligible for WIC. A fixed address is not a Program eligibility criteria. The migrant farm camp or local WIC Clinic address can be used for certification purposes if no other information is available.

II. Native Americans

A. All Reservations in Montana are provided WIC services and benefits. Seven Tribal Governments in Montana contract with DPHHS for the provision of WIC services and benefits.

B. (Financial Eligibility, see policy 5-24) for Native American households.

III. Homeless

A. Homeless individuals who meet the categorical, nutrition risk and income standards are eligible for WIC. A fixed address is not a program eligibility criteria. The local WIC clinic address will be used for certification purposes if no other information is available.

B. Food package prescriptions will take into account the special needs and problems of the homeless individual, such as inadequate refrigeration, cooking facilities, etc. Refer to Policy 8-3.

C. Nutrition education of the homeless will address the special needs of this population.

D. Homeless individuals residing in a homeless facility may receive WIC benefits if that facility meets the criteria described in Policy 5-5 Institutions and Homeless.

E. In addition to the annual WIC press release described in the Outreach and Referral Section, local programs will contact homeless facilities, including shelters for victims of domestic violence and local food banks, to inform them about WIC services to the homeless. Each facility will receive a list of local WIC clinics and outreach flyers.

F. The local programs will request a signed statement that the facility meets the criteria in Policy 5-5 Institutions and Homeless. This statement will be shared with the State WIC Agency and a list of participating facilities must be provided to the State WIC Agency with the annual reapplication.

Policy Number: 5-21
Application/Certification
Effective/Revised Date: October 1, 2005

Application/Certification

Purpose

Provide guidance to Local Agencies on procedures required for certifying WIC applicants/participants.

Authority

7 CFR 246.7 and State Policy

Policy

The applicant must meet categorical (pregnant, breastfeeding or postpartum woman, infant or child up to age five), residential, financial and nutritional eligibility criteria.

Categorical, financial and residential eligibility can be determined by the WIC Aide. Nutritional eligibility must be determined by a Competent Professional Authority (CPA)

Note: Refer to the WIC User Procedure Manual for instructions on the certification process in the automated system.

I. Appointments

Note: Parent/Guardian must be present at certification/subcertification appointments.

A. The request for service may be made in person or over the phone.

B. When new participants make an appointment with the WIC clinic, WIC staff must start a file for the family.

C. Fill in both the participant/parent/guardian name and document the date the appointment was made in the initial contact blank on the CFES form.

D. This date starts the federally regulated timeline in which a participant is to receive notice of their eligibility/ineligibility.

E. Clinics should inform applicants of required documents for certification:

1. Identification (individual documentation).
2. Residency documentation (family documentation).
3. Income Documentation (individual documentation).
4. Certification Form and Eligibility Statement (family documentation).
5. Rights and Responsibilities Form (family documentation).
6. 24-hour Recall and Diet History (individual documentation).
7. Anthropometric test results (if required).

F. Participants should be encouraged to call in to make or cancel appointments.

G. Participants will be seen by appointment in all Montana WIC clinics. "Appointment time" means the time the participant/applicant is due to report to the clinic. The clinic will make every effort to serve the participant on time.

H. If a participant/applicant walks in for service without an appointment, she/he will be considered a "walk-in," and be served after participants with appointments.

I. Participants with appointments will be considered "on time" if they arrive within +/- 15 minutes of their appointment time. Participants who arrive early should not expect to be seen early (but may be seen earlier if circumstances allow).

J. A participant who arrives more than 15 minutes late is to be treated as a walk-in.

K. All policies developed by local programs for appointments, scheduling and missed appointments shall be reviewed and approved by the State Office prior to implementation.

L. All locally developed policies shall be prominently displayed in the office and otherwise communicated to participants to assure awareness of the policy. See Policy 4-2, Local WIC Program Policies.

M. The first month's food instrument issuance must coincide with the appointment at which the participant is notified of eligibility. Subsequent appointments for determination of eligibility should coincide with food instrument issuance.

N. Appointments are written on the participant's WIC ID Packet and if applicable, recorded in the automated system.

O. Office hours must be posted in a conspicuous place so participants are aware of normal clinic hours and any non-traditional hours.

II. Notification of Eligibility

A. Special nutritional risk applicants (pregnant women and migrant farmworkers) must be notified of their eligibility/ineligibility within 10 days of the date of the first request for program benefits. Local programs may receive an extension of the notification period to a maximum of 15 days upon written request to the State WIC agency. The request must include a justification of the need for an extension.

B. If a pregnant applicant misses an initial appointment, the WIC staff will attempt to contact her by phone or mail to reschedule the appointment.

C. All other applicants shall be notified of their eligibility/ineligibility within 20 days of the date of the first request for program benefits

IV. Notification of Ineligibility

1. An applicant/participant is determined ineligible for one of the following reasons:
   A. Categorical status (does not meet the definition of categorical eligibility);
   B. Residential status (does not reside in Montana);
   C. Financial status (participant/family does not meet financial guidelines);
   D. Nutritional status (has no nutritional risk, see chapter 5).

V. Procedure to Follow when a Participant is Found Ineligible

A. Applicant/participant is advised of his/her ineligibility with an explanation. During an active certification period, a 15 day advance written notice of ineligibility must be provided along with a food package to cover the 15 day time period. Advise the participant of the date on which the current period of eligibility will expire.

B. Mid-Certification termination - Any time a participant does not meet all of the criteria (categorical, residential, financial, nutritional) to be eligible for WIC benefits, they must be found ineligible.

C. Give participants a Notice of Ineligibility and a final food package (one month maximum). If the participant already has received WIC checks to the end of the 15 day notice time period, do not issue more food benefits.

D. Applicant/participant is informed of Fair Hearing procedure as described on “Notice of Ineligibility” form.

E. A “Notice of Ineligibility” form must be completed and the participant/parent/guardian and WIC staff must sign the Notice of Ineligibility each time a participant is found ineligible.

F. If the non-automated form is used: the yellow copy is to be given to the participant and the white copy must be maintained in the participant chart.

G. When an applicant is found ineligible for WIC benefits, local programs must provide information about other potential sources of local food assistance identified in the outreach/referral plan as well as other assistance the applicant may need.

H. The Certification Form and Eligibility Statement (CFES - green sheet) is to be used for all certifications/subcertifications.

I. For first time certifications of a WIC participant, clinic staff must post the initial contact date on the CFES to begin tracking the timeline for notice of eligibility/ineligibility (please refer to Appointments, and Notification of Eligibility and Notification of Ineligibility).

J. Clinic staff must also ask participants if they will be moving from the State during their certification time period and offer them a VOC card.

K. The participant will fill out the top portion of the front page indicating Applicant/Guardian, Address, Phone Numbers and list who is in the household.

V. Identification

A. Identity must be documented at all certifications/subcertifications, transfers and when a participant or proxy picks up WIC checks. WIC staff will indicate what was viewed for identity documentation in the "persons living in household" portion of the front page of the CFES (the shaded block on the CFES, revised 6/03) or in the progress notes.

B. For ease of identification at future appointments, a copy of what was viewed for identification may be kept in the participant file to be used at subcertifications or food instrument pick ups. Use of the participant ID packet, after issuance by your clinic, can also serve as identity documentation.

C. After issuance of an ID Packet, in order to use the ID Packet as identification, there must be a copy of original identification in the participant file.

VI. Residency

A. Residency must be documented at all certifications/subcertifications and transfers. WIC staff will indicate what was viewed as residency documentation on the top portion of the front page on the CFES (the shaded block on the CFES, revised 6/03) or in the progress notes.

B. A copy of what was viewed for residency documentation may be kept in the participant file to be used at subcertifications. At subcerts, be sure and ask participants if their address is (still) current when using old documentation.

VII. Income

A. Fill out the mid-portion of the front page on the CFES indicating what was used for income documentation for all income in the household (see Financial Eligibility, Documenting Income, Chapter 5, pgs. 86-87).

B. For age appropriate (working age) participants in the household claiming no income, document household composition (how are rent, utilities, meals divided). Document your questions and answers in the progress notes. See Zero Income section, Chapter 5, page 5-85.

C. Income can be used for other certifications in the household for up to 60 days with no further documentation, however signatures on the CFES must be obtained at all certifications/subcertifications.

D. An exception to the 60 day income documentation allowance is a participant using a Medicaid card as income documentation. Local Agency (LA) WIC staff must verify MA eligibility for the month in which certification or subcertification occurs, as Medicaid eligibility is determined on a month-by-month basis using SIS or some other adjacent eligibility program.

VIII. Eligibility Verification

A. Review with the participant the last portion of the front page on the CFES (who might have access to their WIC information and the "Eligibility Verification Statement"). The participant and LA WIC staff must sign and date the front page of the CFES for every certification, no 60 day coverage (do not have the participant sign/date the front of the CFES prior to certification). If signatures/dates are missing, the CFES is not valid for certification purposes.

IX. Nutrition

A. The CPA determines and indicates nutritional risk codes (both the # code from policy 5-12 and a description) on the back page of the CFES. After explaining the nutritional risk to the participant/parent/guardian, the LA WIC staff and the participant must sign and date the back page of the CFES. If signatures/dates are missing, the CFES is not valid for certification purposes.

B. The above procedures for filling out the CFES are to be done at every certification/subcertification.

C. LA WIC staff shall ensure the participant/parent/guardian reads and understands their rights and responsibilities as noted on the CFES under "Note:", "Eligibility Verification Signatures" and the "Discrimination Notice" on page 2.

D. Notification of the following is provided through the WIC ID Packet and Rights and Responsibility Form which is signed by the participant/parent/guardian and a LA WIC staff member at all ceritifications/subcertifications: "It is illegal to participate in more than one WIC Program at the same time."

E. The forms (CFES and Rights and Responsibilities) must be signed at each certification (no 60 day coverage from last signature) and kept in the participant's file. A copy must be offered to the participant.

X. Transfers

A. In-State. Local programs that have a Montana WIC participant transfer into their program shall have the participant fill out a CFES form, show ID and Residency and sign and date the CFES and Rights and Responsibility forms after reading them.

B. Out-of-State with a VOC Card. Local programs who have a an out-of-state WIC participant with a VOC card transfer into their program shall have the participant fill out a CFES form, show ID and Residency and sign and date the CFES and Rights and Responsibilities forms after reading them. If proof of residency is not available at the initial visit request verification at the subsequent visit.

C. All participants transferring to a local WIC program (either from in-state or out-of-state with a VOC) shall be asked if the income they expect to receive is at or below WIC income guidelines based on household size.

D. All transferring participants need to bring in income documentation at their next visit in ensure they remain income eligible.

XI. Official Notification of Certification End

A. All participants must be issued the "End of Certification/Notice of Ineligibility, form #128, when their last set of WIC checks for the current certification is issued along with form #103, "Notice of Certification Appointment".

B. Form #103, "Notice of Certification Appointment", allows clinic staff to mark and explain to participants which items are required for a subcertification. The form is to be signed and one copy given to the participant and one copy kept in the participant chart (see attached copy of form).

MONTANA WIC PROGRAM

END OF CERTIFICATION/NOTICE OF INELIGIBILITY

Form 128

Participant/Parent/Guardian: _____ID # _____

End of Certification Notice		**Certification End Date**
	The current certification has ended and you need to reapply to continue receiving WIC benefits for: Name _____ Name _____ Name _____ Name _____ The above participant(s) will need to reapply to determine continued eligibility for the WIC Program.	_____ _____ _____ _____

Notice of Ineligibility		**Certification End Date**
	Your child is over five (5) years of age.	
	Your postpartum certification period is over.	
	You are a breastfeeding woman whose infant is over 1 year of age.	
	You do not have a nutritional/medical need for the program.	
	Your family's income is too high.	
	You do not live in the Montana WIC Program service area.	
	You requested withdrawal from the WIC Program.	
	Other: _____ _____ _____	

WIC is an equal opportunity program. If you feel you have been discriminated against on the basis of race, color, national origin, age, disability or sex, write immediately to the Secretary of Agriculture, USDA, Washington D.C. 20250.

_____ _____

Participant/Parent/Guardian Signature WIC Staff Signature Date

WIC Fair Hearing Procedures

If you are dissatisfied with any decision about your eligibility for WIC, you are entitled to a fair hearing.

1. Submit a verbal or written request within 60 days of denial of participation to either your local WIC office or the State WIC office: WIC Program Coordinator, Cogswell Bldg., Helena, MT 59620 (406) 444-5533.
2. You will then receive a copy of the Montana WIC Hearing Procedures.
   - You may be represented by an attorney or anyone at the hearing.
   - The hearing shall be within 3 weeks of receiving the request and shall be convenient for you.
   - You will have 10 days written notice of the time and place of the hearing.
   - The hearing will be conducted by an impartial official.
   - You have the right to present any evidence on your behalf.
   - You will be given the final decision in writing within 45 days from the date of the request for hearing.

MONTANA WIC PROGRAM
NOTICE OF CERTIFICATION APPOINTMENT

Form 103

REASON FOR NOTICE:

An appointment for WIC certification has been scheduled for:

_____ on _____ at _____ AM/PM.
_____ on _____ at _____ AM/PM.
_____ on _____ at _____ AM/PM.
_____ on _____ at _____ AM/PM.

Please bring all items checked to this appointment. This information is needed to qualify you and/or your family member(s) for WIC benefits. If qualified, WIC checks may be given at this appointment. If this appointment is not kept, the above participant(s) will be terminated from the WIC Program.

❑ 1. The participant(s) named above.

❑ 2. Proof of all current household income (**one month pay stubs, closest to the appointment day**) _____ _____or
Proof of current participation in TANF, Food Stamps or Medicaid _____ _____ or
Other: _____.

❑ 3. Proof of current residency (**utility bill; rent receipt/agreement**) _____ _____.

❑ 4. Proof of identification for the above named and for the parent/guardian _____ _____.

❑ 5. Completed 24-hour diet recall/health history and/or infant questionnaire **(please fill out both sides before your appointment**,)

❑ 6. Other requested information: _____ _____,

WIC looks forward to working with you and your family. Please call ahead if you are unable to come to your appointment.

For questions or information call: _____
_____

_____ _____
Participant Signature Local Agency Signature Date

XII. Organization of WIC Chart Information

A. WIC charts in local clinic s are exclusively WIC. The chart must contain the necessary documents to validate certification. An efficient arrangement is to assemble the administrative/financial documents on the left-hand side and the nutrition/health records on the right-hand side. Nutrition and health records should be grouped within a family chart by each individual participant. Listed below is suggested chart arrangement:

1. Left-Hand Side:

   a. Certification Form and Eligibility Statement documenting financial and nutrition eligibility, signed and dated.

   b. Participant's Responsibility Form (required as of January 1, 1996).

   c. Release of Information signed and dated (if needed and specific). General Release of Information forms may not be used.

   d. WIC Fair Hearing information.

   e. ID and residency.

2. Right-Hand Side:

   (a) Prenatal Weight Gain Grid with measurements recorded and plotted.

   (b) Infant/Child Growth Grid with measurements recorded and plotted.

   (c) 24-hour Recall or Nutrition History

   (d) Medical history information for identified risk factors.

   (e) Nutrition Education Checklist/Progress notes.

   (f) Documentation of follow-up on referrals. Include name of the provider the participant has been referred to and the reason for the referral.

Policy Number: 5-22
Categorical Eligibility
Effective/Revised Date: October 1, 2005

Categorical Eligibility

Purpose

Provide guidance to Local Agencies of which applicants would be categorically eligible for WIC services.

Authority

7 CFR 246.7 & State Policy

Policy

All applicants must be categorically eligible for WIC services to receive benefits.

Introduction

I. Categories

A. Women are categorically eligible during pregnancy and up to six weeks following termination of the pregnancy. Postpartum women are eligible up to the infant's first birthday if they are breastfeeding or up to 6 months postpartum if not breastfeeding.

B. Infants are eligible until their first birthday.

C. Children are eligible until their fifth birthday.

II. Definition

Persons who meet the definition of pregnant women, breastfeeding women, postpartum women, infants or children.

Policy Number: 5-23
Residential Eligibility
Effective/Revised Date: October 1, 2005

Residential Eligibility

Purpose

Provide guidance to Local Agencies in determining participant residency eligibility.

Authority

7 CFR 246.7 & State Policy

Policy

Participants must reside in Montana to receive Montana WIC benefits.

Introduction

I. Geographic Area

A. Applicants should receive WIC services in the geographic area where they reside (see Special Situations below). In the case of Reservations or agencies operating programs in more than one geographic area, these geographic areas may overlap.

B. Exceptions can be made for Special Situations (see below). Such situations must be documented in the family folder.

II. Residency Documentation

Residency must be documented at each certification and transfer. Documentation of residency must be from a utility bill, monthly rent payment receipt or landlord statement (documentation connecting participant with current address). See Policy 5-21 for how to note residency on the CFES.

III. Special Situations

A. In the event a participant resides in a geographic area served by one WIC program and works or receives their health care in another geographic area served by a different WIC program, participants may choose to receive WIC services in the geographic area where they work or receive their health care under the following conditions:

1. The WIC clinic in the chosen geographic area has a slot available for the participant and agrees to serve them, but
2. If clinics have been instructed by the State Office to implement waiting lists, participants must receive WIC services in the geographic area in which they reside.

3. If a participant resides in an area that is not served by a local WIC program, but adjoins a county that does have a WIC agency, the participant cannot be served in the adjoining county unless they receive health services in that county, the WIC clinic has a slot available for the participant, there are retailer agreements in place and participation is approved by the State WIC Office on a case-by-case basis.
4. Participants residing in an area not served by WIC are encouraged to actively seek WIC in their county by contacting physicians, county commissioners, welfare departments, public health nurses, low income advocacy groups, etc.

IV. Verification of Certification Cards

A. VOC cards are used for transferring WIC participants from one state to another state. VOC cards are the same as a WIC certification and may be used until the end of the current certification period.

B. VOC cards are to be accepted by local programs as proof of certification when presented by transferring participants.

C. An automated VOC card is available on the WIC system. The local programs will issue cards to all participants who intend to transfer out-of-state. One card is issued for each transferring participant.

D. Residency and ID must be obtained for WIC participants transferring from one state to another.

Note: Issue VOC cards to migrants upon certification. See Policy 5-21 when a participant does not meet residency eligibility requirements.

Policy Number: 5-24
Financial Eligibility
Effective/Revised Date: October 1, 2005

Financial Eligibility

Purpose

Provide guidance to Local Agencies in determining current financial eligibility/household size for WIC applicants.

Authority

7 CFR part 246.7 and State Policy

Policy

WIC applicants are to be determined financially eligible based on the current income guidelines and their household size. Local Agencies must determine the best indicator of the households' current financial situation through interviewing the applicant at certification.

Introduction

I. Income Instructions

A. These income instructions are not intended to make income determination for WIC a complicated and lengthy procedure, nor are answers readily available for every question on a specific case.

B. There will be times when State and local WIC clinic staff need to use their discretion in determining financial eligibility within the general framework of regulatory requirements and basic program policy when a participant is not financially eligible.

II. Determination

A. Questions may arise as to who to include as a household member or what to include as income. Although you may have to use your own discretion in some instances, the following information is intended to provide assistance in answering questions from households and in making income eligibility determinations.

B. Refer to the WIC Program Definitions of "Family/Economic Unit," "Emancipated Minor" and "Income" to aid you in determining eligibility.

C. Use either the family's income during the past 12 months or the family's current rate of income (see definition of "current income"), whichever is the best indicator of the family's current status.

D. The purpose of evaluating both current and averaged income (over the past 12 months) is to determine "which indicator more accurately reflects the family's current status."

Example: A family's current income is above 185% of poverty; however, the average income over the past 12 months (or the previous income tax year) is below 185% of poverty. Therefore, the family is financially eligible based on the second test (averaged income) **if the averaged information is reflective of their current status** (seasonal or construction workers might meet this test).

E. If current income is reported as other than an annual figure, the appropriate annual calculation will be made in the WIC automated system.

F. If at any point during an eligible certification a participant (household) is determined to be over the income limit for WIC, they must be given a 15 day ineligibility notice (form #128) and food benefits to cover the 15 day time period, the participant (household) must be removed from the WIC program and the ineligible participant (household) referred to other forms of assistance (food stamp program, food bank, etc.).

III. Adjunctive Eligibility

A. Persons who report they are enrolled in specific qualifying State or Federal programs in Montana must provide proof of such participation for the month of WIC application. Local Agencies may not use a previous certification (within 60 days) financial determination when a participant is using adjunctive eligibility.

B. Participants using adjunctive eligibility do not need to provide additional financial proof as they are adjunctively (automatically) income eligible for WIC. Participants who claim adjunctive eligibility status do not fill out the zero income form, but need to self-declare their income.

C. The self-declared income figure must be recorded in the paper chart and the computer for data collection purposes. (no zero income figures are to be recorded in the computer)

D. Participation in Federal or State administered programs which routinely verify income, that are not listed, must be approved by the State WIC Agency.

E. Programs Providing Adjunctive and/or Presumptive Eligibility

1. Temporary Assistance to Needy Families (TANF - formerly AFDC)
2. Food Stamps
3. Medicaid (includes Medically Needy program, where participants receive eligibility on a monthly basis)

F. TANF or Medicaid applicants who are found presumptively eligible pending completion of the eligibility determination process are also automatically WIC income eligible. These applicants must show proof of presumptive eligibility.

The WIC office must issue only one month benefits and get documentation of final eligibility before issuing further benefits.

IV. Participants Continuing WIC Eligibility

Persons found adjunctively/presumptively eligible do not lose their WIC eligibility upon cessation of benefits from TANF, Food Stamps or Medicaid. A decision about the participant's continuing WIC eligibility must be based upon a reassessment of the household size/income against the WIC Program Income Guidelines.

V. WIC Eligible from Different Programs

A. Programs in which participation probably means they are also eligible for WIC, but for which you must verify and document income are:

1. Public Assistance
2. SSI
3. Commodity Food Distribution
4. School Lunch (free and reduced price)
5. Low Income Energy Assistance

VI. Adoption

When the welfare agency has placed a child in a permanent home and/or subsidizes the child's adoption, the child is considered a member of that household. The family size and total income of the family determine the child's financial eligibility for WIC. When a family has an adopted child or a child for whom the family has accepted legal responsibility, the child is counted in the family size of that family. The size and total income of that family shall be used to determine the child's income eligibility for WIC.

VII. Alimony/Child Support

Any money received by a household in the form of alimony or child support is considered as income to the receiving household. However, any money paid out for alimony or child support may not be deducted from that household's reported gross income.

VIII. Economic/Family Unit

A. A group of related or unrelated individuals who are living together as one economic unit and sharing and consuming household costs, goods, foods, etc..

B. Residents of a homeless facility or an institution shall not all be considered as members of a single family.

C. Students who are temporarily away at school should be counted as members of the family.

D. The terms "economic unit" and "family" can be used interchangeably. We perceive a family to be a household or an economic unit composed of a person or group of persons who usually (although not necessarily) live together and whose production of income and consumption of goods or services are shared.

Example #1: The mother and child live together and receive child support payments from the father. The father has remarried and lives with his new wife who is expecting a baby.

The new wife and the ex-wife apply for WIC benefits. The ex-wife and her child are a family of two, and the child support payments are counted as income. The father and the new wife can be counted as a family size of three (husband, wife and unborn child - see policy #5-3).

The child support payments cannot be deducted from the father's income and the child living with the ex-wife cannot be counted in the father's family unless the father has the child one-half of the time (see joint custody) and is on or applying for WIC services.

Example #2:

If a child resides in a school or institution and the child's support is being paid for by the parent or a guardian, the child may be counted in the family size of that parent or guardian.

IX. Emancipated Minor

A. A minor living alone and without economic support from other persons or living with relatives or friends, none of whom is an adult, but as a separate economic unit is considered to be a household of one. Age is not a factor in defining an emancipated minor.

B. If the household is one economic unit (sharing and consuming household costs, goods, foods, etc.), all income and household members must be included to determine financial eligibility.

C. It is entirely possible for two separate economic units to reside under the same roof, although the determination of such is usually not a clear cut process and these situations should be handled on a case-by-case basis.

X. Foster Care Children

A. See policy 5-6 for documentation procedures to use for foster children and letter after policy 5-6 requesting issued WIC checks be returned from parent/guardian.

B. A foster child is a family/household of one and the income determination is based solely on the foster child's income. Income includes funds provided by the human services agency which are specifically identified by category for the personal use of the child and other funds received by the child, such as money which may be provided by the child's family for personal use.

C. A foster child is not included in the foster parents' household nor is the income received for the foster child's care counted in the foster parents' household income.

D. When a child is placed in foster care, issue only one month of WIC checks per visit as their situation may change rapidly without notice. When a foster child is placed in foster care or back with his/her parent/guardian, the parent/guardian is responsible for returning issued WIC checks/food. If necessary, the clinic will send the parent/guardian a letter asking for the WIC checks/food back and advising the parent/guardian if they cash any of the issued WIC checks after the child was removed from their custody, they will be prosecuted for fraud.

E. The clinic will then void the returned WIC checks as "in-hand" (using the foster care placement letter as "in-hand" documentation) and reissue new WIC checks to the foster parent for the participant.

F. If a foster child is returned to his/her birth family, an income eligibility evaluation must be done based on the household income.

XI. Joint Custody

A. Perhaps the most difficult situations occur when joint custody has been awarded and the parents cannot cooperate in the use of WIC checks. The child's eligibility could change monthly, weekly or even daily depending on the rotating time period at each household.

B. It is the goal of the WIC program to see the child receives the benefits to which the child is entitled during their period of eligibility.

C. Local programs shall determine who has custody the majority of the time during the month and issue WIC checks to that parent. If the custody is in fact divided evenly and the parents will not work together AND if both households qualify for WIC participation, the food package could be issued alternate months to alternate parents. In all instances it must be made perfectly clear the food is for the child's use.

XII. Lump Sums

A. Lump sum payments or large cash settlements (i.e., funds provided as compensation for a loss that must be replaced, payment from an insurance company for fire damage to a house). These are not counted as income since they are not received on a regular basis.

B. When lump sum payments are put into a savings account and the household regularly draws from that account for living expenses, the amount withdrawn is counted as income.

XIII. Self-Employment Income

A. Self-employed persons (includes self-employed persons/farmers) may use last year's income as a basis to project their current year's net income, unless their current net income provides a more accurate measure. Documentation would be a current income tax form or if a current tax form is not available, applicants would be required to bring in their business books.

B. Self-employed persons are credited with net income rather than gross income. Net income for self-employment is determined by subtracting business expenses from gross receipts. Gross receipts include the total income from goods sold or services rendered by the business. Deductible business expenses include the cost of goods purchased, rent, utilities, depreciation charges, wages and salaries paid and business taxes (not personal Federal, State or Local income taxes).

C. Net income for self-employed farmers is figured by subtracting the farmer's operating expenses from gross receipts. Gross receipts include the value of all products sold; money received from the rental of farm land, buildings or equipment to others; and incidental receipts from the sale of items such as wood, sand or gravel.

D. Operating expenses include cost of feed, fertilizer, seed and other farming supplies; cash wages paid to farmhands; depreciation charges; cash rent; interest on farm mortgages; farm building repairs; and farm taxes (but not Federal, State or Local Income taxes).

E. For a household with income from wages and self-employment, each amount must be listed separately. When there is a business loss, income from wages may not be reduced by the amount of the business loss. If income from self-employment is negative, it should be listed as zero income

XIV. Seasonal Income

A. Seasonal income is determined by averaging a yearly amount (e.g. if the participant works five months of the year, the gross amount would be divided by twelve to obtain a yearly average, example: the

B. Participant makes $400.00 every two weeks ($800 a month). Five Months x $800.00=$4000.00. $4000.00/12=$333 a month.

XV. Zero Income

A. Households declaring no income must sign the zero income statement form and understand the provisions of the form:

1. They may have to provide additional documentation to verify their statement.
2. They must give an accurate and true representation of their current income

B. Ask the following questions and document responses for anyone using a zero income statement:

1. Where are they living;
2. Who is paying rent;
3. Who is providing food, daily necessities, etc.

C. If they are living with someone, that family's income could be counted depending on the answers supplied to the above questions.

D. Anyone with zero income must be referred to all appropriate assistance agencies in the area and that referral documented in the participant record.

E. Local Agencies are to issue only one month of WIC checks and schedule an appointment the following month. The following month check the participant's financial eligibility again. They possibly now have income, are adjunctively eligible to participate in WIC due to referrals to public assistance programs or are now living in a household for which you need to check income.

XVI. Income

A. Documenting Income. All participants/applicants must show proof of household income or documentation of enrollment or presumptive eligibility in a qualifying adjunctive program (TANF, FS, MA).

B. Payroll check stubs (minimum of 1 month), tax returns, Medicaid eligibility, Food Stamp eligibility, TANF eligibility, letter of award for unemployment, or letter of award of SSI payments can be used for documentation.

Overtime income would be counted based on the frequency and amount received. Look at the year-to-date on a pay stub to determine if the overtime income would count (i.e., on April pay stubs, the participant has earned $1,000 in overtime. This would compute out to a yearly overtime amount of $3,000).

C. Local Agencies must either take a photocopy of original documents and attach to the participants file or record the following information on the Certification Form and Eligibility Statement:

1. Date of issuance, time period covered or other identifying information
2. Document number
3. Employer name
4. Gross dollar amount
5. To whom the income is issued

If any of the above criteria are missing from the form of financial documentation, you must photocopy the document and place in the chart.

D. WIC participants from the same family certified within 60 days of each other, do not require a second financial eligibility determination within the 60 day period, unless they are using MA adjunctive eligibility.

If a participant (household) is using Medicaid as adjunctive/presumptive eligibility, then the second certification requires income to be documented.

E. The participant and WIC staff will need to sign the CFES form for each certification. Certifications more than 60 days apart require separate financial eligibility determinations.

F. Instream migrant farmworkers and their family members with expired VOC cards shall be declared to satisfy the State WIC Agency's income standard provided that the income of that instream migrant farmworker family is determined at least once every 12 months.

G. Any determination that members of an instream migrant farmworker family have met the income standard, either in the migrant's home base area before the migrant has entered the stream for a particular agricultural season, or in an instream area during the agricultural season, shall satisfy the income criteria for any subsequent certification while the migrant is instream during the 12-month period following the determination.

H. Income amount for out-of-state transfers is based on self-declared income until further documentation is received or the next certification.

XVII. Income Not Counted

A. Income not to be reported or counted in the determination of a household's eligibility for WIC includes:

1. Any cash income or value of benefits a household receives from any Federal program that excludes such income by legislative prohibition, such as the value of food stamps provided under the Food Stamp Program. (See WIC Regulations, Subpart C - Participant Eligibility 246.7 (c)(2)(iv)(c)(8) page 281). Any subsidy a household receives through the prescription drug discount card program must not be treated as income in determining income eligibility for the WIC Program (Section 1860D-31(g)(6) of the Social Security Act).
2. Student financial assistance, such as grants and scholarships, provided for the costs of attendance at an educational institution received from any program funded in whole or part under Title IV of the Higher Education Act of 1965 is excluded from income (ref. 7CFR246.7(c)(2)(iv)(L)), including:
   a. Pell Grant
   b. Supplemental Educational Opportunity Grant
   c. State Student Incentive Grants
   d. National Direct Student Loan
   e. PLUS
   f. College Work Study
   g. Byrd Honor Scholarship
3. Loans, such as bank loans, since these funds are only temporarily available and must be repaid.
4. Income received under the National Flood Insurance Program (NFIP) shall be excluded when determining household income.
5. The Department of Defense is providing funds to certain members of the Armed Forces and their families through the Family Subsistence Supplemental Allowance (FSSA). When determining household income through September 30, 2006, these funds shall be excluded.
6. The value of in-kind compensation, such as military on-base housing, or any other non-cash benefit. (A military cash housing allowance is not counted as income, but other military benefits received in cash, such as food or clothing allowances, CONUS or OCONUS COLAs, must be considered as income (see policy 5-4 Military Personnel Income).
7. Occasional earnings received on an irregular basis (i.e., not recurring, such as payment for occasional babysitting or mowing lawns). You may need to make a judgment on receipt of this income.
8. Overtime Income may or may not be counted based on the frequency and amount received. Look at the year-to-date on a pay stub to determine if the overtime income would count (i.e., on April pay stubs, the participant has earned $1,000 in overtime. This would compute out to a yearly overtime amount of $3,000).

9. Earned Income Tax Credit funds received by a member of the household, whether received throughout the year or as a lump sum.

B. There are limited exceptions where income documentation would not be required. These would include, but not be limited to:

1. An individual for whom the necessary documentation is not available (individuals who have lost everything due to theft, fire, flood or other disaster).

2. An individual, such as a homeless woman or child, for whom the requirement would present an unreasonable barrier.

3. Certain in-stream migrant farmworkers and their family members with expired VOC cards.

C. Check with the State WIC Office to verify if an income documentation exception would be allowed.

XIII. Native American Households

A . Definition: "Native American household" is defined as containing at least one enrolled tribal member, pursuant to the resident Tribe's enrollment requirements.

B. Documentation of a household member's enrollment must be maintained in the participant file (on the CFES - Reservation Program form).

C. Each Reservation program shall post in a conspicuous place Policy #5-2, which shows maximum family income allowed for family size.

D. Income documentation for Native American WIC households living within Reservation boundaries shall be as follows:

1. Each applicant participating in a Reservation WIC program, or the applicant's parent or caregiver, shall sign the Certification Form and Eligibility Statement – Reservation Program (provided by the State WIC office) stating the applicant's family income does not exceed the maximum. This will be done at each certification.

Note: Participants using tribal enrollment as income verification do not need to fill out the zero income statement, just declare their income on the Certification Form and Eligibility Statement – Reservation Program.

E. Each Reservation WIC program may verify income eligibility of any Native American applicant according to established WIC policies and published WIC regulations and record the correct income amount in the certification record.

F. Length of residency in the service area will not be considered a test for eligibility. The Reservation boundary will be the service area.

G. Non-Native American applicant households shall not use the above abbreviated income procedure even though they may be served by the Reservation program.

Policy Number: 5-25
Nutritional Eligibility
Effective/Revised Date: October 1, 2005

Nutritional Eligibility

Purpose

Provide guidance to Local Agencies in completing the nutrition counseling/risk assessment portion of a WIC certification.

Authority

7 CFR 246 and State Policy

Policy

All applicants must be assessed a nutrition risk by the CPA to be eligible to receive WIC benefits.

I. Introduction

The Competent Professional Authority, CPA, evaluates and analyzes the applicant's nutrition and medical information and identifies nutrition risks as defined in Policy #5-12. When a participant does not have a nutritional risk, see Policy 5-21, Notification of Ineligibility.

II. Nutritional Eligibility Determination

A. A diet recall covering a 24-hour period must be completed by the participant and evaluated by the CPA. It should include all food, beverages, etc., taken by mouth or tube feeding with descriptions of preparation method and portion size eaten. Reference evaluation to the "Montana Food Guide Pyramid" appropriate for age/category and food tables such as Bowes and Church's, Food Values of Portions Commonly Used or USDA's Handbook 8.

B. Instructions, methods and procedures for weighing and measuring the length/stature of women, infants and children are found in the Anthropometric Module after this section.

C. Hematological measurements - refer to the Anthropometric Module and Hematological Testing after this section. WIC staff must also ask participants/parents/guardians at cert/subcertification if their child(ren) have had a blood lead screening test. If they have not, they must be referred to programs where they can obtain such a test.

D. The participant is assigned a priority and the CPA informs the WIC participant/guardian of the nutrition risk(s) which qualify her/him for the WIC Program. See Chapter 5, Policy 5-21, for instructions in filling out the CFES form.

E. Once eligibility has been determined, the CPA develops a nutrition care plan and provides the initial nutrition education contact (see chapter 6 - Nutrition Education). The CPA then assigns the appropriate food packages. **Food packages are always assigned by the CPA**.

Hematological Testing Procedures

Purpose

To ensure hematological testing is provided in a safe manner which places participants/staff at lowest risk possible for contact of blood-borne illness, while obtaining accurate hematological measurements.

Authority

State Policy

Policy

Local Agencies will use the following procedures to perform hemoglobin/hematocrit testing for WIC participants.

I. Requirements for Local Clinics

A. The following applies for local clinics which perform their own hematological tests:

1. Before performing any laboratory tests, the WIC clinic must be covered by a Laboratory Registration Certificate.
    a. Under the Clinical Laboratory Improvement Amendments (CLIA) of 1988, all facilities which perform laboratory tests must be registered with the Department of Public Health and Human Services.
    b. The type of laboratory tests performed will determine the level of certificate of registration and mandatory staff required.
2. Micro-spun hematocrit tests and hemoglobin tests using the HemoCue® Method are classified as waived tests.
3. A Laboratory Director must be designated.
4. Staff performing waived tests must, as a minimum, have a high school degree or G.E.D.
5. Advanced degrees apply only if the degree is related to medical laboratory science.
6. The Montana WIC Program will purchase a CLIA Registration Certificate which will cover local clinics at their request if they perform only waived hematological tests for the WIC Program.

B. If the local WIC clinic is included in an arrangement where other laboratory tests are performed, whether waived or not, it must obtain its own certificate of registration or be covered by another WIC agency's certificate.

Example: The Public Health Nurse of the county is the WIC staff person who performs all laboratory tests for WIC and performs laboratory tests as part of her other job duties.

A certificate of registration should be obtained by the Public Health Nurse to cover her section or the county may wish to obtain a certificate which covers the entire department.

C. If the local WIC clinic performs non-waived laboratory tests, it must obtain its own certificate of registration or be covered by another WIC agency's certificate.

1. To be included in the Montana WIC Program Laboratory Registration Certificate, the local WIC program must:

a. Request inclusion with the WIC Laboratory Director, Chris Fogelman, at the State Office.

b. Provide the required information requested on location of sites where laboratory tests are performed, days and hours of operation (when tests are performed), and names, education level and years of experience for staff performing the tests. This information will be sent to the Department of Health and Human Services.

c. Submit changes in any of the information required above to the WIC Laboratory Director as they occur.

d. Understand that if any one of the local clinics under the certificate are found in violation and required to discontinue laboratory tests, all local clinics under the certificate will be required to discontinue laboratory tests.

e. The Montana WIC Program's Laboratory Registration Certificate is CLIA ID# 27D0700313 and is valid until August 2007.

II. Safety Requirements

Local WIC program staff performing hematological tests must follow the universal precautions procedure described in Policy 5-16 or procedures established by the employer, whichever are more restrictive.

Note: Remember that in any invasive procedure, whether drawing blood for a hematocrit or hemoglobin, universal precautions must be observed.

III. Equipment

A. Hematocrit Screening: The hematocrit is expressed as the percentage of erythrocytes to total blood volume or as the volume in cubic centimeters of erythrocytes packed by centrifugation. A centrifuge is necessary for this separation. (Erythrocytes are red blood cells.)

1. A centrifuge is an instrument which spins capillary tubes at high speeds. The centrifugal force created causes the heavy red cells to settle on the bottom and the lighter plasma to go to the top. The white blood cells are heavier than the plasma and lighter than the red blood cells and form a thin layer between the two.

Additional equipment necessary to obtain the hematocrit are:

a. Blood lancets

b. Capillary tubes

c. Gauze swabs

d. Rubbing alcohol

e. Clay tube sealer

f. Hematocrit reading chart

g. Bandaids (optional)

2. Method of Testing. Local WIC programs may choose the method of hematological testing which best meets their situation. They may purchase the supplies and equipment to perform the tests themselves or contract for services using funds from the local budget.

IV. Hematocrit Screening

Technique for Specimen Collection: Blood may be obtained from capillaries in the finger. For an infant, obtaining the capillary blood sample from the toe or heel may be easier.

A. Sterilization

Step #	Procedure
1	Wash and dry hands, put on gloves. Set up materials needed.
2	Select a finger. Circulation can be stimulated by having the child hold his hand down and making a fist several times.
3	Find a comfortable and safe way to hold the child's hand. One method is palm to palm, with a firm grasp of the entire hand. With preschool children, use the parent's help.
4	Cleanse the skin with a 70% alcohol swab and **dry** the finger before making the puncture.

B. Collecting a Blood Sample – Finger Stick Procedure

Step #	Procedure
1	Using a sterile, disposable lancet, make a quick but firm jab into the fleshy part of the fingertip. Be prepared for a sudden instinctive withdrawal movement by the patient.
2	Wipe away the first drop of blood with a dry gauze square (not cotton)
3	When the second drop of blood appears, fill the tube by means of capillary action and gravity to 1/3 to ¾ full. You may want to tilt the tube down to help the flow of blood.
4	Fill two capillary tubes.
5	Air bubbles can be present in these tubes without creating any problems.
6	**Do not** squeeze the finger or "milk" it. Squeezing or "milking" forces tissue fluid into the sample resulting in an incorrectly low hematocrit reading. If the puncture does not bleed freely, a second puncture should be made.
7	Gently invert the blood sample 5 to 10 times to mix the heparin (anticoagulant) with the blood.
8	Seal the tube with plastic clay. Insert the end of the tube in the clay, putting the finger over the end of the tube when inserting in clay. Rotate the tube in the clay. Be gentle – capillary tubes break easily.
9	To complete the finger stick procedure, wipe the patient's finger with a clean cotton or gauze swab to the punctured area to stop any further bleeding. Bandaids should be available if excessive bleeding continues

10	Promptly dispose of the lancet. It is necessary to have a container to put the lancets and capillary tubes in after they are used. A plastic gallon milk jug works well for this container. Do not throw used lancets and capillary tubes in a waste can as the cleaning persons may be injured.

C. Foot Stick Procedure: (Optional. Used only for infants).

Step #	Procedure
1	Foot sticks are essentially the same as finger sticks. A rubbing motion from the toes to the heel on the bottom of the foot prior to the stick will help stimulate the blood flow, especially if the baby's foot is cold. Babies may also be stuck in the big toe.
2	Grasp the infant's foot firmly in your hand. Babies can display great amounts of resistance and kick vigorously.
3	Follow the same procedure for cleaning the puncture site and collecting the sample as in Finger Stick Procedure Step 4. **Note: Do not do a foot stick on an infant who walked to the clinic barefoot.**

D. Using a centrifuge

1	Loading centrifuge. Open "see through" machine cover and head cover and insert tubes in numbered channels in head. Place sealed end of tube toward outer rim of head, flush against rubber gasket. Always balance tubes in machine. **Secure both** covers. Rotate times knob to spin head for five minutes. **Do not** open cover of centrifuge until the spinning has stopped.
2	Heparinized tubes of blood can stand up to 4 hours before centrifuging, but must be read as soon as centrifuge stops. If tiny aid bubbles are present in the tubes after they are spun down, discard the tube and repeat the procedure.
3	Do not read the hematocrit directly from the centrifuge. Use the Lancer Critocap Microhematocrit Capillary Tube Reader (Read-a-Card), taking care to line up and maintain the bottom line of blood in the capillary tube with the zero mark on the card. The tube must be perpendicular to this line. The tube is then moved from side to side along the bottom line until the clear fluid level at the top intersects the 100 percent line. The line corresponding to the top of the packed red blood cells is the hamatocrit score. Note: You must be directly above the reading card. Reading the card from an angle will give a false reading (parallax error). The reader card is more accurate than the chart attached to the centrifuge. The reader card must be used to assure comparability among specimens. Specimens should be run in duplicate. If the result upon reading the specimens is a difference of less than three percentage points (for example, 35% and 36%), average the two values. If the result varies by more than three percentage points, discard the specimens and redraw. The averaging recommendations are from Dr. Ray Yip at CDC.

4	Dispose of all capillary tubes in a sharps container for contaminated items. All other non-sharp items contaminated with blood must be disposed f properly.
5	Remove gloves and dispose of properly. Wash hands. If another participant is to be tested, select new gloves and begin the procedure again

E. Maintenance of Centrifuge

1. Follow the manufacturer's instructions for calibration, cleaning and maintenance of centrifuge devices. The centrifuge of a clinic doing a small volume of hematocrits should be inspected every four months. The rubber strip in the outer groove of the head should be replaced when torn or indented. The locks and brushes should be replaced when worn. The time should be checked against an electric clock or stop watch.
2. Centrifuge heads should be regularly cleaned with soap and water. Most instrument malfunctions are due to dirt. The centrifuge should pack the cells in a five minute period of time. If this does not occur, the centrifuge requires maintenance.
3. Centrifuge should be calibrated annually.

F. Hemoglobin Screening

1. In the red blood cell is a molecule called the hemoglobin. It contains iron and is able to "carry" or bind oxygen. The hemoglobin test is a laboratory test to determine the concentration of hemoglobin in the blood. Two methods are now available to determine hemoglobin.
2. HemoCue®
   a. The HemoCue® system measures undiluted blood photometrically after conversion to hemoglobinazide.
   b. The HemoCue® system consists of disposable micro-cuvettes with a reagent in dry form and a photometer specifically designed for its function. The micro-cuvette is used for measuring the sample, as a reaction vessel and as measuring cuvette. Reading of the hemoglobin takes place in the photometer following the completion of the reaction and the result is displayed in the window.

Sterilization

The general procedure instructions are:

Step #	Procedure
1	Wash and dry hands, put on gloves. Set up materials needed.
2	Seat the participant comfortably. If her/his fingers are cold, it is a good idea to heat the hand from which the sample will be taken in warm water.
3	Use only the middle finger or ring finger for sampling. It is important that the blood can circulate freely in the sampling finger, so fingers with rings should

	be straight but not tense, to avoid stasis effect which occurs when the fingers are bent.
4	Clean the puncture site with an alcohol swab and let dry.

Collecting a blood sample

Step #	Procedure
1	Using your thumb in a gentle rocking movement, lightly press the participant's finger for the sample from the top knuckle to the tip. Gentle pressure should be used. Prick the side of the tip of the finger with a lancet or other appropriate device. Not only is blood flow best from this site, it also causes the least pain.
2	Using a dry absorbent pad, wipe away the first two or three drops of blood. This stimulates spontaneous blood flow and reduces the chance of error due to contamination. If necessary, apply light pressure again, until another drop of blood appears, but avoid "milking." The manufacturer recommends that the first two to three drops of blood be wiped away to increase the accuracy and consistency of results.
3	If a second sample is to be taken from the same site, it is important this be done immediately after the first has been taken. Wipe away the remains of the third drop of blood and take a second sample from the fourth drop.
4	Dry off any surplus blood on the tip of the cuvette. Make sure that no blood in sucked out of the cuvette.

Using a HemoCue®

Step #	Procedure
1	Place the cuvette in the holder and insert it in the photometer.
2	When and only when the reaction has been completed, approximately 45 seconds, the blood-hemoglobin value is displayed in the window.
3	As with all contaminated cuvettes and used swabs (cotton balls or gauze), proper disposal procedures must be followed.
4	Remove gloves and dispose of properly. Wash hands. If another participant is to be tested, select new gloves and begin the procedure again.

Maintenance

Follow the manufacturer's instructions for calibration, cleaning and maintenance of HemoCue® devices.

Photometric measurement

The second method is a photometric measurement of hemoglobin after conversion to hemoglobincyanide. The instrumentation needed for the procedure is generally not available in WIC clinics.

Other Methods

If you are investigating other methods of hematological screening, please contact the State Office.